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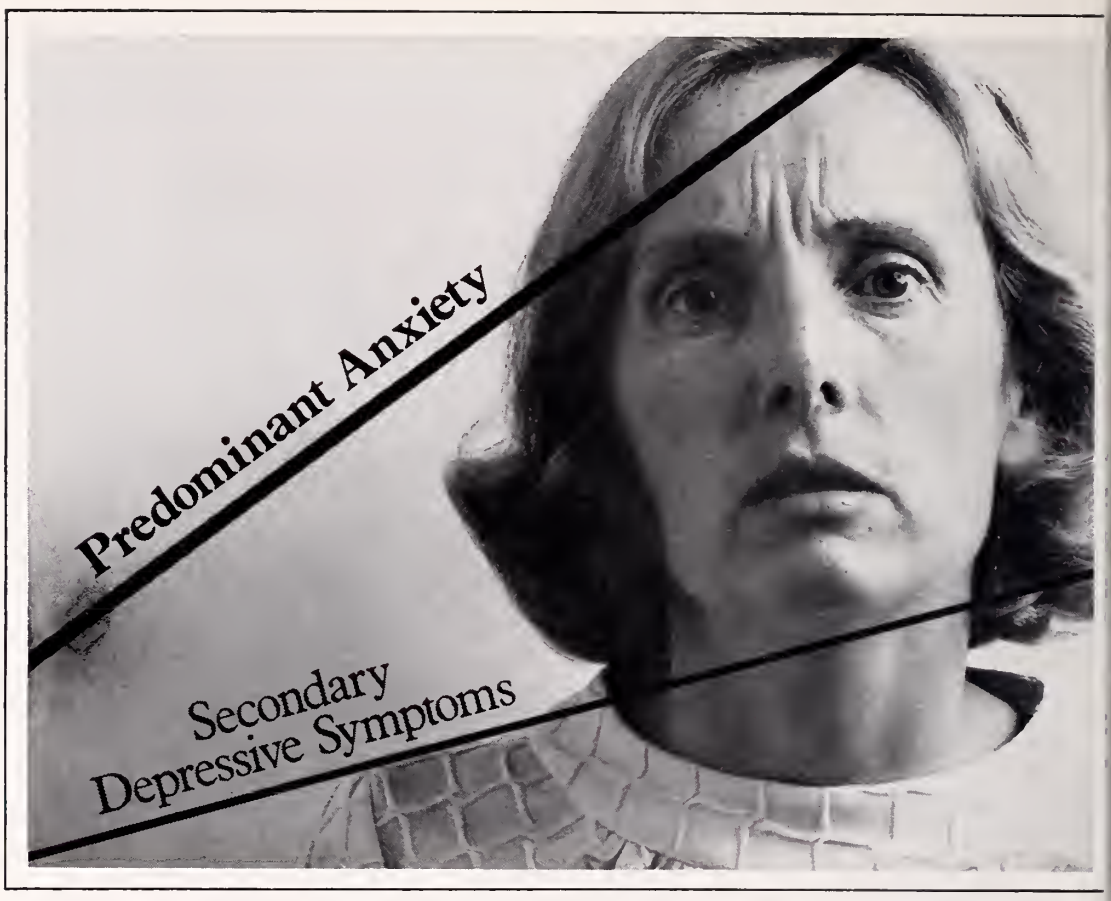

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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

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JANUARY
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Vol. 70 No. 1

The
WEST VIRGINIA
Medical Journal

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The Board of Directors of the Pharmaceutical Manufacturers Association

The National Wholesale Druggists' Association

Joint Statement on Antisubstitution Laws and Regulations

The purpose of this statement is o affirm the support of the participat- ng organizations for the laws, regula- ions and professional traditions which prohibit the unauthorized substitution of drug products.

Traditionally, physicians, den- ists and pharmacists have worked cooperatively to serve the best inter- ests of patients. Productive coopera- ion has been achieved through mutual respect as well as a common concern for the ideals of public service. This mutual respect has been reflected, in part, by joint support over the years for the adoption and enforcement of laws and regulations specifically prohibiting unauthorized substitution and encouraging joint discussion and selection of the source of supply of drug products. The basic principles of medical, den- tal and pharmacy practice are thus utilized and preserved in the interest of patient welfare.

The antisubstitution laws have not obstructed enhancement of the professional status of pharmacy any more than they have in and of them- selves guaranteed absolute protec- ion from unsafe drugs, or freed physicians, dentists and pharmacists from their responsibilities to patients. As a practical matter, however, such laws and regulations encourage inter- professional communications regard- ng drug product selection and assure each profession the opportunity to exercise fully its expertise in drug usage, to the advantage of patients.

Physicians and dentists should be urged to increase the frequency and regularity of their contacts with pharmacists in selection of quality drug products, recognizing that economies to patients can be im- proved through such communica- tion, taking into account the patients' needs. The pharmacist's knowledge of the chemical characteristics of drugs, their mode of action, toxic properties and other characteristics that assist in making drug selection decisions should be utilized to the fullest extent practicable by physi- cians and dentists in serving their patients.

Since drug product selection entails knowledge derived from clinical experience, the physician's and dentist's roles in product selec- tion remain primary and do not per- mit delegation of decisions requiring medical and dental judgments. A broader role in therapy will evolve for pharmacists as improved under- standing and cooperation among the professions continue to grow.

There has been no evidence that there are convincing reasons to modify or repeal existing laws and regulations prohibiting the unauthor- ized substitution of another drug product for the one specified by a prescriber. It is our belief that such laws and regulations merit the joint support of the medical, dental and pharmaceutical professions and the pharmaceutical industry.

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Specific Learning Disabilities In Children

William B. Svoboda, M. D.

The physician who treats children is frequently confronted by a parent seeking a reason and a remediation for her child who is failing at school despite suspected capabilities. The physician, the teacher and the parents share in common the frustration of observing the erratic and incomplete performance of the child who seems to have the ability to do better. Many of these children have some of the cluster of learning problems now known as Specific Learning Disabilities which prevent them from achieving their learning potentials. These specific learning disabilities now can be specifically diagnosed and thus specifically remediated if the child is discovered, referred and adequately evaluated.

Definition

A specific learning disability is a disorder of one or more of the basic psychologic processes involved in the understanding or usage of spoken or written language. This may involve visual-motor skills or audio-vocal skills or both. These may manifest as disorders of listening, of thinking, of speaking, of reading, of writing, of spelling or of arithmetic. The problem is not necessarily dependent on the intellect and indeed may lower the true intellectual capacities. The child of average or above average intelligence may be able in part to circumvent his block by various mnemonic tricks; the child of below average intelligence is already basically limited in his abilities . . . any further block may completely inhibit further learning.

Secondary specific learning disabilities also exist. These are disabilities due to a primary problem such as a visual handicap, a hearing problem, a motor or movement handicap, a mental or emotional problem, a prior educational lack or to an environmental or social problem.

The Author

- **William B. Svoboda, M. D., Assistant Professor, Pediatric Neurology, and Head of the Division of Learning Disabilities, West Virginia University School of Medicine, Morgantown.**

These individual abilities are inborn related skills which like an assembly line, process incoming stimuli stagewise through decoding organization and recoding of the derived information into a manner of expression. By nature we are all endowed with varying skills. It is only when an ability is so underdeveloped as to inhibit performance, i.e., to imbalance learning, that it becomes a disability. Any ability can be developed; it is only the potential of that ability that limits the response. Musical abilities would be an analogy. Two individuals may begin piano lessons. Both will eventually learn to play the piano but the individual with greater inherent talent will make further progress than the individual of limited native talent.

Learning disabilities tend to be disguised in numerous diagnostic terms of non-specific nature. Such entities as perceptual handicaps, minimal brain damage-dysfunction or injury, the hyperkinetic syndrome, cerebral palsy, developmental dyslexia, dysgraphia, aphasia, agnosia, apraxia, dyscalculia, anarithmia as well as various adolescent and pre-adolescent emotional problems may have specific learning disabilities as a significant if not the basic component. Problems in school that are manifestations of the specific learning disabilities include difficulties with reading (dyslexia), with writing and spelling (manual and verbal dysgraphia) with arithmetic (dyscalculia, anarithmia), in speech, in attention, in

memory, or in the understanding, comprehension and expression of ideas.

Though these problems may be acquired at any age through a direct insult to the brain (such as a stroke, a trauma, or a metabolic problem) by far the most common childhood representation is as an underdevelopment or a developmental delay in that ability. There rarely are any valid and significant findings on EEG or even on autopsy examination of such a brain. The most common findings are of variances from the expected normals, the so-called soft signs which indeed are other manifestations of developmental delays. These immature signs would be normal in a younger child. A true pathologic finding would be abnormal at any age and is often only coincidentally found in the child with a learning disability.

The Developing and Developed Brain

The plasticity of the developing brain does not have the strict localization of these functions that the adult "set-in-its-way" fully developed brain has achieved. The developing brain has the inherent ability to transfer a skill to an adjacent cortex or to develop the same skill in the opposite hemisphere if damage should preclude development in the original locus. The developed brain has lost this ability to shift the skill through the full development of the skills. Thus, a disability is far less localizing in the child unless it is an abrupt loss with prior normal developmental functioning. Basically then, in the childhood learning disabilities, localization by psychologic testing or correlation to EEG abnormalities or various abnormalities on the neurologic examination often is inaccurate and usually only speculative.

Basic Processing

In basic learning experiences we commonly receive our information via two avenues of stimulation, namely, sight and sound. We express our ideas through speech or through a motor act such as in writing, drawing or gesturing. We do also receive stimuli by other sensory modalities but these are not common vehicles of learning save perhaps in handicapped individuals and in multisensorial remediative approaches.

We process these stimuli into expression through three main stages, namely, reception, integration with other past and present stimuli, and then expression of the formulated idea. We do this for sound and we do this for sight.

We process these stimuli on at least two levels. We process on a basic or automatic level. The secretary who types a dictated letter may do so with great accuracy and speed yet may not be aware of the content. This is an automatic process and it relates to accuracy, effort and rate. We also process stimuli on a higher level for we receive many stimuli as a symbol (e.g., a word spoken or written) which represents a concept. We must decode this symbol into a concept, integrate it to other past and present experiences and then recode it into a spoken or written symbol again as a means of expressing our formulated ideas. This higher or representational level involving symbolic comprehension is similar to the entity of aphasia and relates most closely to understanding, comprehension, formulation—expression of ideas, and thus to basic intelligence.

A person can have a problem in automatic functioning and as a result struggle with many bizarre errors, despite much effort and a slowed rate but yet comprehend amazingly well. Similarly, a person can basically produce fairly adequately but not comprehend what he produces when he has a problem of the higher level of representational processing.

Indications

A child who performs significantly beneath his suspected ability may have a learning disability. A child who comprehends fairly well but performs inaccurately with much effort and a slowed rate, or the child who performs with acceptable accuracy and rate but lacks comprehension, may have a learning disability. The child who essentially learns through hearing and expresses himself through speech but is unable to adequately learn by sight (reading) or to express himself through writing, or the child who reads and writes acceptably but appears not to understand what he hears or to be able to express himself accurately in speech . . . both may have learning disabilities. Thus handicapping imbalances of performance/capabilities, comprehension/accuracy and audiovisual/visuomotor processing should alert the observer to the possible existence of a learning disability.

Significant signs indicating a learning disability are found in the child's performance. The physician, teacher or parent who observes the types of errors rather than the number of errors may make the presumptive diagnosis.

The more specific indications of a learning disability may be applied to auditory stimuli and processes as well as to visual processes. The child may have difficulties in recognizing, discriminating and differentiating the received stimuli from other similar stimuli. He may spatially confuse and disorient items he sees. He may have a poor memory. He may recall items

but recall them in the wrong order. He may not recognize a stimulus unless he perceives the entire stimulus and if he receives only a partial stimulus he may be unable to complete the item in his mind. This can affect his grammatic abilities and his phonetic abilities. He may have speech problems such as delayed onset or maturation of speech, scant and superficial efforts, tangled and disordered performance, immature patterns and mispronunciations.

He may have problems in recognizing the stimulus for its meaning, particularily if the meaning is a concept. He may have problems in comprehending the significance and relationships of the stimulus to past and present items in order to derive an idea. He may have difficulties in formulating the derived ideas into an expression. A problem in any or all of these skills most likely is the manifestation of a learning disability, be it for a visuomotor problem or an audiovocal problem.

There are some common manifestations of learning disabilities that are less specific but still suggestive. Incoordination of fine or gross movements are common to visuomotor process disabilities and probably represent efforts to respond to faulty visual sensation. Spatial, laterality, and directionality confusions as well as right-left confusions also are common to visuomotor processing problems and are other manifestations of faulty visual sensations.

A hyperkinetic syndrome is commonly found with learning disabilities. The hyperkinetic behavior may be the cause of scattered learning disabilities or it may be the result of a disability in receptive processes. The principal manifestations of the hyperkinetic reaction are (1) excess of uncontrolled and unproductive energy, (2) distractability, (3) behavioral problems, (4) emotional hyperreactivity and (5) poor social interactions with sibs, peers, parents and teachers.

The typical emotional reactions to the daily frustration of not succeeding in learning are essentially those of a flight or fight reaction. These manifest primarily into five types of reactions, namely; (1) indifference to the problem, (2) defeatism and drop-out reaction, (3) anger and resentment, (4) anxiety and (5) discouragement and depression. These become especially evident and may become the most prominent problem as the child approaches adolescence.

Many notable personalities have experienced learning problems. Retrospective reviews of their childhood efforts are highly suggestive of learning disabilities. Such notables as Thomas Edison, Harvey Cushing, Albert Einstein, Hans Christian Andersen, Woodrow Wilson, George Patton and Lee Harvey Oswald are numbered among those with suspected learning disabilities. One can only speculate how their later lives were affected by their early academic frustration.

Diagnosis

The learning disability may be identified and confirmed by three cooperative approaches, namely; (1) by a review of history of the learning problems and the neurophysical examination, (2) by review of the academic performance and the types of errors and (3) by formal psycholinguistic testing of the language processing. In more simple terms the problem can be considered (1) as the physician might see it, (2) as the teacher might see it, and (3) as the psychologist might see it.

Medical History Essentials

The medical history should review the family status and heredity, the socio-economic status, the environment, the prior academic experiences, the family attitudes toward learning and the medical history. The history may yield traumatic experiences, avoidance reactions, undue family pressures, sensory deprivation, multiple or inadequate language experiences, deficient prior school experience or depreciatory family attitudes as contributory factors.

The physical examination may demonstrate visual or hearing defects. The child may demonstrate spatial confusions, left-right confusions, incoordination, mixed laterality, speech problems, undernourishment, poor body image, or hyperactivity.

The examination proper may demonstrate some physical or neurological disorder which interferes with adequate school attention and performance. Visual problems may be missed for commonly vision is tested at 20 feet whereas reading and writing are performed at much closer range. Vision testing by a near vision hand card may be better unless the child sees the letter stimulus clearly but confuses it for a similar letter because of a perceptive disability. If the tester does not realize the true cause for the depressed performance, the child may be fitted for glasses without need.

Observation of the performance in academic tasks often can reveal much if the error type is determined. The performance also should be judged for rate, accuracy and comprehension. Reading should be observed and compared both

by aloud and by silent methods. Listening comprehension should be tested. Writing (and spelling) and drawing should be evaluated and compared by spontaneous, dictated, visual recall and copy approaches.

Complete psycholinguistic evaluation should be obtained to cover *all* stages of processing. Too often only a few stages are adequately evaluated and the child thus does not appear to respond well to therapy for the real problem may be missed. Psychological examination may suggest poor visual or auditory perceptive and discriminative skills, poor concept understanding and interpretation, disorganization, poor generalization abilities, limited expressivity, reduced motor or verbal skills, poor memory skills or learning imbalances in performance. An excellent basic test battery covering many of these defects is the *Illinois Test of Psycholinguistic Abilities.* Unfortunately, this battery does not cover or adequately indicate errors in auditory and visual perceptive skills and recent reviews suggest that these perceptive skills may be among the most common of disabilities in reading and writing. Though there are no totally satisfactory tests for this area of perceptive skills, commonly used and simple tests include the *Wepman Test of Auditory Discrimination*, the *Bender Gestalt Test* and the *Marianne Frostig Developmental Test of Visual Perception*, among others.

If the history and physical examination, the academic problems and the formal psycholinguistic testing agree in the diagnosis, the disability is confirmed. If there is disagreement, the probability is that either an item was missed or a handicap was somehow circumvented.

Remediation

The approach toward the handling of the learning disability is threefold: (1) the specific identification of the disability, (2) the specific remediation of the disability and (3) the monitoring of the response to the remediation by retesting. The aims of the testing are twofold: (1) to find strengths for use in basic learning, and (2) to identify weaknesses for specific remediation. The remediation should be interesting, useful, encouraging, motivating, and pertinent to the age needs and interests of the child. Often the parents are best advised to leave formal remediation to the schools and other remediative groups and to limit their efforts to encouragement, support and involvement of the child in games and non-pressure exercises within the areas of his weakness.

Formal remediative approaches must be tailored within the available programs of the various school districts and regional remediative centers which are developing in cooperation with various centers throughout the state actively engaged in diagnostic and remediative supportive services.

Summary

The concept of specific learning disabilities and the manifestations related to these problems are presented with the concept of diagnostic approaches for the specific disabilities to derive specific remediative approaches. The concepts, cardinal historical features and diagnostic approaches as utilized by the West Virginia Medical Center Learning Disabilities Clinic are outlined and the aims of the remediative approaches are briefly presented.

A list of references may be obtained by writing The Journal.

A Difference of Opinion

CAN a person's spine get out of alignment, press on nerves and thus cause many different forms of illness? Chiropractors say yes, but the first experimental study of that "subluxation" theory says no. Dr. Edmund S. Crelin, professor of anatomy at Yale University School of Medicine, found that subluxation of a vertebra "does not occur." He studied the effects of pressure applied to the spinal columns of six persons within six hours of their deaths and noted, "the nerves did not become unduly stretched when the column was maximally twisted."

Common Polypoid Lesions Of The Colon and Rectum: Their Significance and Management*

Leonard Peters, M. D., and Alvin L. Watne, M. D.

MANAGEMENT of polypoid lesions of the colon and rectum has been clouded by many factors including confusing terminology, and controversy regarding their benign or malignant nature or predisposition. No argument will be advanced at this time for or against the polyp-carcinoma relationship. Despite the on-going controversy, reasonable deductions can be made regarding the clinical significance of various polypoid lesions, and rational therapeutic plans can be carried out in light of our current state of knowledge.

Diagnosis

The fundamental tools of physical diagnosis are vital for the proper assessment of patients with such lesions. Each patient should be carefully questioned regarding change in bowel habit, tenesmus, rectal bleeding, abdominal pain, weight loss, or mucoid stools. A family history of colon polyps or colon carcinoma should be recorded. A complete physical examination is imperative and must include digital rectal examination and proctosigmoidoscopy. An air contrast barium enema is a necessary adjunctive measure to define the magnitude of the presenting problem and to search for associated lower gastrointestinal tract pathology.

On digital rectal examination, induration, degree of fixation, and extent of the lesion serve as guides to the presence of invasive tumor. If a polyp is visualized on proctosigmoidoscopy, particular attention should be paid to its size, shape, texture and mobility. The presence or absence of a stalk should be determined, and one should look for areas of ulceration. Barium enema studies must be carefully scanned for associated lesions, and all filling defects should be accurately measured.

Although the clinical assessment of polypoid lesions is important, diagnosis can be made only by histological examination. The pathology will establish the diagnosis, dictate the management, and provide a clue to prognosis. The pathologist must inform the surgeon of the presence or absence of blood vessel invasion, lymph vessel invasion, and invasion of polyp stalk or the underlying muscularis mucosae.

*Supported by the Charleston Foundation for Cancer Research; West Virginia Grand Aerie, Fraternal Order of Eagles; and American Cancer Society Clinical Fellowship.

The Authors

- **Leonard Peters, M. D., Resident in Surgery; and Alvin L. Watne, M. D., Professor of Surgery; both at the West Virginia University School of Medicine, Morgantown.**

Table I gives the description of polypoid lesions as modified from Morson and Bussey. There are four categories of polypoid lesions of the colon to be discussed. These are (1) metaplastic (hyperplastic) polyps, (2) juvenile (retention) polyps, (3) adenomatous polyps, and (4) villous (papillary) adenomas.

Clinical presentation, gross and histologic appearance, clinical significance and management will be discussed for each type of lesion. A number of less common entities will be omitted from this discussion. One should remember, however, that carcinoid tumors, heredofamilial polyposis, submucous lipomas, fibromas, leiomyomas, malignant melanoma, lymphoid polyps, lymphosarcomas, metastatic carcinoma and hypertrophied anal papillae are encountered and can present as polypoid colon and rectal lesions. Pseudopolyposis associated with inflammatory lesions such as ulcerative colitis, diverticulitis and amebiasis are also seen.

Metaplastic Polyps

Metaplastic polyps probably are the most common of all intestinal polyps, but surprisingly little is known about them. The term, "metaplastic," is used only to describe a change in the appearance of the mucosa as compared with the normal.

Table 1

Histologic Classification of Benign Intestinal Polyps

Unclassified	Metaplastic Polyp
Hamartomas	Juvenile Polyp Peutz-Jeghers Polyp
Neoplastic	Adenoma Papillary Adenoma Villous Papilloma
Inflammatory	Benign Lymphoid Polyp

These lesions are known also as hyperplastic polyps, simple polyps and small mucosal polyps.

The gross appearance of these lesions is characteristic. Certainly all physicians who have performed proctosigmoidoscopies have encountered these small, plaque-like nodules in the rectal mucosa or, less frequently, in the distal sigmoid colon.

Occasionally a rudimentary pedicle is present, but the majority are sessile and less than one centimeter in diameter. These lesions frequently are multiple and usually the same color as the normal bowel mucosa. Metaplastic polyps are found in patients of all ages, but there is a much increased incidence in patients over 40 years of age. In Arthur's[2] postmortem series, metaplastic polyps were present in 40 per cent of those less than 40 years of age and in 75 per cent of those over age 40. There was no sex predilection.

Microscopic features are distinct from those seen in adenomatous polyps (Figure 1). Mucosal tubules are of varying lengths, and there is some tendency toward cystic dilatation. The lining epithelial cells tend to lose their regular columnar and goblet cell pattern, with infolding and patchy flattening of cells giving it a serrated appearance. This has been compared to the endometrium during the late secretory phase of the menstrual cycle. Cellular nuclei are large, rounded and usually located in the central or basal portions of the cell. Mitotic activity is modest. The muscularis mucosae deep to the polyp frequently fragments into an interlacing network of fibers, some of which extend toward the surface between dilated tubules.

To our knowledge, these lesions have never produced significant symptoms, and no specific therapy is indicated once the diagnosis is established. The significance of these lesions still is the subject of debate, as they have been classified as (1) hamartoma, (2) mucosal response to inflammation or trauma, (3) benign neoplasm and (4) a degenerative process. The relative infrequency during childhood and lack of significant inflammation histologically mitigate against the first two possible etiologies. Some have felt that metaplastic nodules might be an early stage in the development of adenomas. Morson[3] refuted this by noting that transitional forms between metaplastic polyps and adenomas are not seen. Further, he states that there would be a disproportionate number seen in patients with adenomas of all sizes, such as those with familial polyposis coli. Arthur[2] notes that Cole demonstrated differences in the uptake of tritiated thymidine in the epithelium of metaplastic polyps and adenomas.

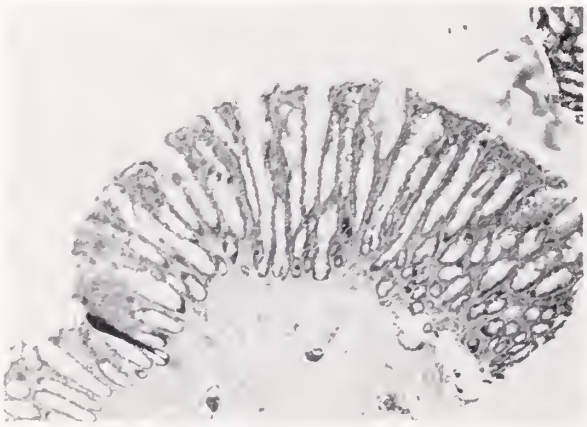

Figure 1. Low power photomicrograph of a metaplastic polyp demonstrating mucosal tubules of varying lengths and moderate cystic dilatation. There is fragmentation of the muscularis mucosae.

Degenerative in Nature

A likely explanation is that metaplastic polyps are degenerative in nature as reflected in their predominance in the population over 40 years of age. Based on the study by Weakley and Swinton,[4] there is no suggestion that they are premalignant. In a series of 295 cases of metaplastic polyps, carcinoma of the colon subsequently developed in three cases, while the *expected incidence* was two and two-tenths cases.

Juvenile (Retention) Polyps

Juvenile or retention polyps are relatively rare lesions. Helwig[5] reported an incidence of 3 per cent in a series of 449 consecutive autopsies on persons under 21 years of age. Shapiro[6] noted juvenile polyps to account for 3.7 per cent of all patients seen with proctologic disorders of infancy and childhood. Males are involved more than females in about a three to two ratio. The overwhelming majority of patients (90 per cent plus) with this lesion present in the first decade of life, with an average age of four and one-tenth years.[7] It should be stressed, however, that this lesion can occur throughout adult life, with Roth and Helwig[7] reporting such a histologically confirmed lesion in a 61-year-old patient.

Presenting Symptom

The most common presenting sympton (80 per cent) is bright red rectal bleeding in small quantities during or immediately following a bowel movement.[7,8,9] The bleeding characteristically stops rapidly, and exsanguinating hemorrhage is not a reported complication. About one-third of children will have prolapse or protrusion of the mass from the anus. This has been compared in appearance to a mulberry, cherry or piece of meat. The most striking feature is its dark red

color in contrast to the much lighter normal rectal mucosa. Abdominal cramps or pain is present in a varying number of patients and is more common in the presence of polyps with a long pedicle than with sessile lesions. The pain is usually located in the lower abdomen and occurs when the polyp is in the more mobile segments above the rectosigmoid. The mechanism is thought to be on the basis of traction on the bowel wall by the pedicle as the polyp acts as a foreign body and is carried along by the intestinal peristalsis trying to expel it from the body. Self-amputation and spontaneous extrusion occur on occasion in the pediatric age range, while diarrhea, constipation and intussusception are rare. A few lesions in adolescents or adults will first be discovered on routine proctosigmoidoscopy.

According to Harrillemo[8] and associates, approximately 75 per cent of juvenile polyps are found in the rectum and nearly all of these are palpable on rectal examination. Most lesions have definite pedicles, and about 25 per cent of the patients have two or more lesions. Grossly, juvenile polyps usually are ovoid in shape—some nearly spherical while some are flattened on one axis and may be likened to a lollipop, and a few are mushroom-like. The usual greatest diameter is one to one and one-half cm. with a range from three mm. to four cm. even in infants. The external surface is generally smooth although some are finely granular. A very characteristic beefy red color usually is in evidence. The small lesions tend to be friable, whereas the larger ones are firm and rubbery.

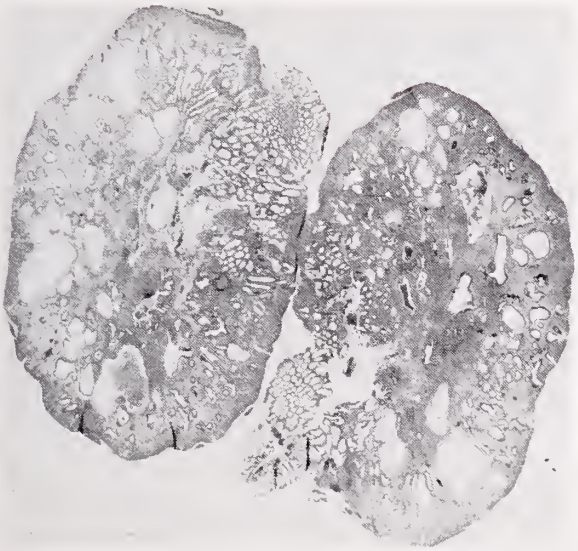

Figure 2. Photomicrograph of a juvenile polyp showing stromal proliferation with marked acute and chronic cellular infiltration. Note the cystic glandular spaces lined with flattened epithelial cells.

The microscopic picture of the juvenile polyps is characteristic (Figures 2 and 3). There is proliferation of glandular and stromal elements with marked vascularity and infiltration with lymphocytes, polymorphonuclear cells, plasma cells and eosinophils. Early lesions may show little more than localized mucosal hyperplasia with active mucous glands. Larger lesions frequently show areas of surface epithelial denudation with replacement by a layer of fibrin infiltrated with polymorphonuclear cells. As this seals off the mucous gland orifices, cystic glandular spaces appear lined by flattened epithelial cells. The actively secreting mucous glands are lined with tall columnar epithelial cells with small basally located nuclei. Goblet cells are numerous and normal mitotic figures are evident. Lymphoid follicles are rare.

As these lesions grow, focal areas of necrosis and hemorrhage are seen more commonly and occasionally infarction results. Although Kerr[9,11,12] and others have reported malignant change, most clinicians feel that these lesions almost never undergo malignant transformation. Roth and Helwig,[7] in analyzing reports of malignant change, note that most have occurred in patients with a heredofamilial form of juvenile polyposis.

Many question whether or not these lesions are true neoplasms. A number of theories of pathogenesis have been advanced for juvenile polyps, and these include retained secretions, hereditary, congenital, inflammatory, allergic and neoplastic. The theory advocated by many observers[7,8,13] is that of inflammation with mucosal ulceration leading to edema and obstruction of colonic glands. The blocked glands proliferate, branch, and dilate, with exposure of a large surface and progression in ulceration and inflammation, with production of granulation tissue, and renewal of

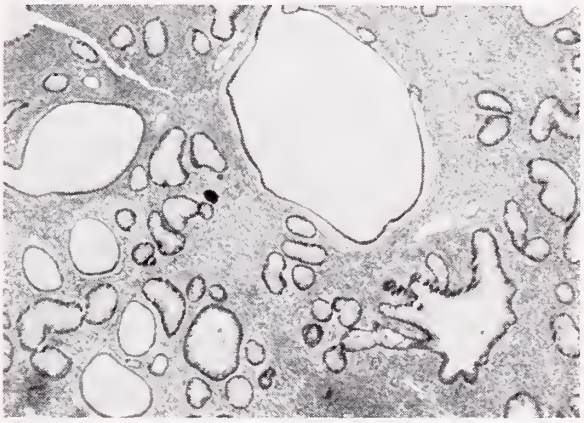

Figure 3. High power of the characteristic cystic glandular spaces and actively secreting mucous glands seen in juvenile polyps.

this cycle until a large, intraluminal lesion is produced. Morson and Bussey,[1] however, feel that juvenile polyps are hamartomas and that secondary infection and necrosis occur and modify the typical histology.

Treatment

Based upon the data available, one can treat the juvenile polyp as a benign neoplasm without malignant potential. Removal is important to relieve the lower gastrointestinal symptoms and rectal bleeding, and to confirm the diagnosis histologically. The majority can be excised with cold biopsy forceps or electrothermic snare through the sigmoidoscope. Polyps low in the rectum may be prolapsed through the anus and excised after pedicle ligation.

Fulguration may be implemented in sessile growths. Lesions above the peritoneal reflection are better dealt with via transabdominal colotomy and polypectomy, or short segmental resection if the polyp has a broad-based attachment. The true recurrence rate of juvenile polyps probably is low. The "recurrence" rates of up to 18 per cent reported,[8] probably represent missed lesions on initial examination. Nevertheless, follow-up visits at six-month intervals for two or three years is recommended.

Adenomatous Polyps

The incidence of adenomatous polyps of the colon and rectum is generally acknowledged to be from five to ten per cent of the general population.[14,15,16,17] Most feel that they occur at least eight times as frequently as villous adenomas, although some writers report "villous changes" in up to 45 per cent of adenomatous polyps.[18] Whereas villous adenomas have a high incidence of malignant change, Grinnell and Lane[19] report a 2.9 per cent incidence of carcinoma in adenomatous polyps. About 26 per cent of the patients have multiple adenomatous polyps,[19] and the incidence of malignant change in this group is reported to be 12 per cent[20] exclusive of familial polyposis patients. The extreme example of this group is the patient with familial polyposis with hundreds of adenomatous polyps. There is close to 100 per cent incidence of malignant change in these patients' colons by the age of 40 years.[20]

True adenomatous polyps are extremely rare in patients under the age of 20 years. The finding of an adenomatous polyp(s) in patients under this age should alert the physician to the possibility of heredofamilial polyposis. The incidence of adenomatous polyps increases after the age of 20 years until the ninth decade of life. Blatt[21] noted that one-third were in patients age 50-69 and about one-half in the 70-89 age range. There is no apparent sex predilection.

The majority of these patients are asymptomatic, with most adenomatous polyps discovered on routine proctosigmoidoscopy or on barium enema performed for other reasons. In the symptomatic patient, the most common presenting complaint is a modest or moderate degree of rectal bleeding, or anemia of unknown cause. Mucous discharge, abdominal pain, prolapse through the anus, and intussusception are rare presenting symptoms. When a polyp is large enough to cause obstructive symptoms, it usually is malignant.[19]

One-half of adenomatous polyps are found in the sigmoid and 28 per cent in the rectum, with the remainder in the more proximal colon.[19] On gross examination, they usually are pedunculated, firm and vary in size from one mm. to several cm. in diameter. The bulbous polyp head is pink to red in color, and usually irregularly lobulated.

Cole and McKalen[22] studied adenomatous polyps histologically after the intravenous administration of radioactive (tritiated) thymidine. This is rapidly incorporated into the nuclei of epithelial cells which are synthesizing DNA preparatory to undergoing mitotic division. Their findings suggest that the initial derangement in the morphogenesis of the adenomatous polyp is a shift in the normal zone of cell regeneration and proliferation from the crypt bases to a more superficial position in the epithelium. This is followed by an excentric growth pattern with subsequent tumor formation and epithelial growth occurring at the surface of the neoplastic lesion.

The early microscopic change is replacement of some of the lining cells of the crypts begin-

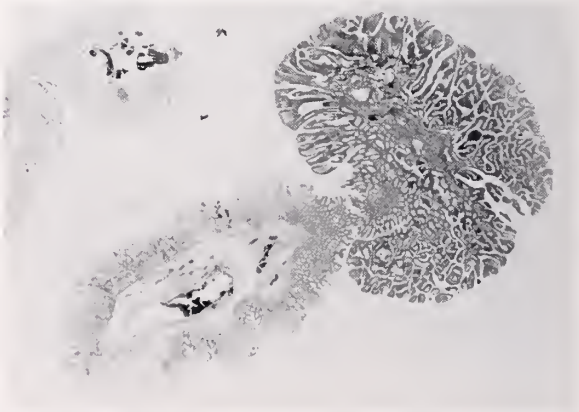

Figure 4. Low power view of an adenomatous polyp showing increased chromaticity and height of the glands covering the head of the lesion. The vascular connective tissue stalk is an extension of normal bowel mucosa.

ning at the base, by cells that are taller, more slender, and more hyperchromatic than normal (Figure 4.) The nuclei stain darkly, and there are few vacuoles indicative of mucin secretion. Mitotic figures can be abundant. As the lesion grows, one notes a vascular connective tissue stalk covered by mucosa which is an extension of the normal adjacent mucosa. This suggests the pedicle is pulled out by peristaltic traction, and is not part of the neoplastic process. The head of the polyp consists of glands with considerable variability in size and shape, but are generally larger and more basophilic than normal.

Polypoid Adenocarcinoma

Not infrequently, small, usually peripheral areas in the head of the adenomatous polyp demonstrate marked pleomorphism, atypical glands and cells, hyperchromatism, and frequent mitosis. This represents carcinoma *in situ*. Truly invasive carcinoma can be diagnosed only when invasion is seen beneath the muscularis mucosae True stalk invasion by malignant glands is unusual, but serial sectioning of the stalk of all polyps is imperative to rule out this possibility. Occasionally, the surgeon removes a polyp which is grossly indistinguishable from an adenomatous polyp, and is shocked to find that microscopically it consists solely of carcinomatous glands. This is the so-called polypoid adenocarcinoma. Most of these lesions are broad and sessile, but occasionally there is a pedicle present.

Until the work of Spratt, in 1958,[23] the adenomatous polyp generally was considered to be a pre-malignant lesion. Controversy has abounded during the past fourteen years regarding this. Despite the fact that the question is not settled, rational therapy can be carried out. Most would agree that the only treatment indicated for an adenomatous polyp, or adenomatous polyp with carcinoma *in situ* is complete removal of the polyp and stalk and fulguration of the base if it is removed transproctoscopically. Transabdominal colotomy and polypectomy or short sleeve resection is indicated for lesions beyond the safe reach of the proctoscope. For adenomatous polyps with malignant invasion beneath the muscularis mucosae or stalk invasion, or for the so-called polypoid adenocarcinoma, a standard cancer operation is mandatory.

How should one approach the suspected adenomatous polyp? It is advocated that all polyps within the reach of the sigmoidoscope be excised and studied histologically by serial sectioning of the polyp and stalk. The finding of malignant invasion beneath the muscularis mucosae of the stalk dictates performance of a standard cancer operation, combined abdominoperineal resection or a low anterior resection.

The practical problem posed by the demonstration of a polyp more proximal in the colon is a challenging one. In order to justify transabdominal surgery for colonic polyps, the chance of malignancy must outweigh the risk of surgical mortality. In spite of the quoted three per cent incidence of malignancy in adenomatous polyps, Welch[20] tells us that 10 per cent of his patients with suspected adenomatous polyps proximal to the reach of the sigmoidoscope will have invasive cancer. Patients with multiple lesions, obstructing lesions, or sessile polyps also have a higher rate of malignancy.

The mortality rate of patients who have operations on the colon for polyps is about two per cent.[20] Studies of 1,041 patients by Pagtalunen and associates[24] and Wychelis and co-workers[25] revealed the absence of invasive cancer in all adenomatous polyps up to one cm. in diameter. Grinnell and Lane[19] found a 1.3 per cent incidence of malignancy in a series of 1,013 patients with polyps less than one and one-half cm. in diameter. In a series published by Lescher and associates[26] an eight per cent incidence of invasive cancer was found in 127 patients with adenomatous polyps greater than one cm. in diameter. Spratt and Ackerman[27] found a twelve per cent incidence of malignancy in the one and one-fourth to two cm. range.

One may conclude, therefore, that with small asymptomatic, round, regular, and stalked polypoid lesions above the reach of the sigmoidoscope, the patient may be safely followed by barium enema every three to six months. The development of safe fiberoptic colonoscopy may allow biopsy of these controversial lesions and better follow-up evaluation. In lesions which exhibit growth, are irregular, greater than one cm. in diameter, sessile, or are symptomatic, laparotomy is indicated and colotomy and polypectomy or short sleeve resection should be performed. Frozen section should be done, and serial sections taken through the stalk. In the majority of cases, no further treatment is needed but in instances of invasive cancer, standard cancer bowel resection should be immediately performed.

Follow-up is mandatory for all patients. For those with malignant lesions, particular attention is paid to the suture line area on sigmoidoscopy and barium enema examinations, at initially three, and then six-month intervals. Periodic blood counts, liver function tests, and chest x-rays

should be obtained. For those patients with benign lesions, follow-up examinations at six-month intervals for at least two or three years is important. In a small percentage of cases, new adenomatous polyps will develop within a short period of time, and in some the size, location or number of them may even dictate performance of a partial colectomy.

Villous Adenomas

The most challenging polypoid lesions of the colon and rectum to manage are the villous (papillary) adenomas. In Southwood's[28] series of 188 cases of villous adenoma, the age range of patients was from 28 to 89 years. The majority, however, were in the 55-80 year age range with four to three male predominance. These lesions are very rare proximal to the sigmoid colon.

The manner and magniture of symptoms are highly variable, and indeed these lesions may be asymptomatic. Two-thirds of the patients will present with bright red rectal bleeding, and nearly as many will have complaints of mucous discharge or watery diarrhea. Weight loss is reported in from 14 to 45 per cent of patients.[28,29] A villous adenoma of the rectum may not commonly present as a prolapsing rectal mass. As reported by several observers,[30,31,32] a small but important percentage of patients will present with severe fluid and electrolyte depletion. Most of these patients are elderly (average of 64 years) and may have had symptoms for a considerable length of time (average of four and two-tenths years).[32] The most striking symptom in these patients is a profuse watery rectal discharge which frequently is passed separately from the normally formed stool. The volume may approach three to four liters per day. In association, vague abdominal pain, tenesmus, and tumor prolapse may occur. The excessive fluid loss leads to excessive thirst, anorexia, progressive weakness, lethargy, mental confusion, orthostatic hypotension, extreme dehydration and oliguria. While the serum calcium and phosphorus remain normal, the urea nitrogen usually is elevated. Electrolyte abnormalities include hyponatremia, hypochloremia and hypokalemia usually associated with decreased carbon dioxide combining power, suggesting metabolic acidosis.

Mechanisms Not Known

The physiologic mechanisms responsible for the increased net fluid and electrolyte transfer into the distal colon are not known. The rectal fluid volume seems to correlate well with the tumor size, surface secretory area, state of the patient's hydration, and secretory cell activity. While the sodium and chloride losses in the rectal fluid are nearly isotonic, potassium concentration is about 13 times serum level, suggesting an active electrolyte transfer system.[30,32,33] Da Cuiz et al[33] suggest that net fluid and electrolyte transfer may be mediated by humoral secretions of the villous adenoma.

Eighty per cent of villous adenomas of the colon are found in the rectosigmoid.[29,32] Many of these will entirely encircle the lower bowel lumen. In spite of their large size and easy accessibility, they may be difficult to palpate due to their characteristic soft texture and mobility. The villous adenoma usually is sessile with the central portion raised more than the periphery. The surface is soft, reddish-gray, fleshy, and convoluted, due to the villous processes which project above the level of the surrounding intestinal mucosa.

Microscopically, these villi are composed of finger-like projections of loose supporting vascular stroma covered by a single layer of columnar epithelial cells (Figures 5, 6, & 7). The epithelial cells are somewhat longer, more slender, and more darkly staining than the normal large bowel mucosal cells. They have darkly staining elongated nuclei and the outer portion of the cells contains less mucous than the usual epithelial cell and at the tumor margin, there is a transitional zone of low papillary growth where villous tumor gradually merges with normal bowel mucosa.

The management of these lesions is complex, but adherence to several basic fundamentals should dictate the logical course of action. Operative intervention should not be undertaken until fluid and electrolyte problems, if present, are under control. Drug therapy to control lower bowel symptoms is ineffectual.

Although a plea for conservative treatment has been advanced by Raminez and associates[34] and

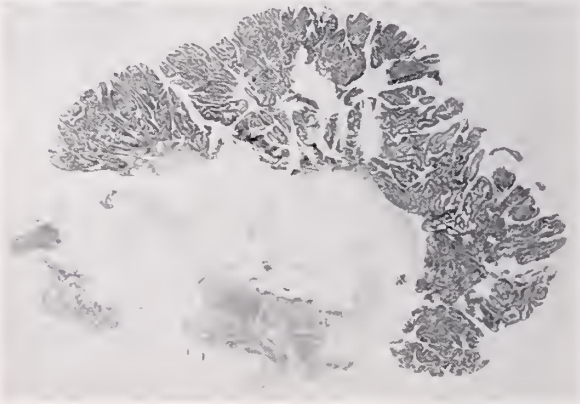

Figure 5. Low power photomicrograph of a vertical cross section of a villous adenoma showing villi composed of a loose connective tissue stroma covered by a single layer of hyperchromatic columnar epithelial cells.

others, most writers feel that fulguration, wire loop cautery, "biting" them out, local irradiation, or external irradiation have no place in the definitive treatment of villous tumors. They may be implemented under extraordinary circumstances as temporary control measures. Complete excision of the lesion with a margin of normal surrounding tissue is the treatment of choice and the only curative procedure. This basically means use of a wide local excision when the tumor is amenable to this, but large tumors frequently require an extensive resection. Evidence compiled by many observers suggests that excision with scalpel rather than use of cautery or fulguration is preferable.[29,35,36]

Incidence of Malignancy

The incidence of malignancy in villous adenomas has been reported in large series to be from eight and one-half to 69 per cent[29,35,37,38] although most would agree to a 30 per cent occurrence. This malignant change may be manifest by a small focus of anaplasia or, at times, a carcinoma will virtually replace all preexisting villous adenoma. The villous adenoma is associated with additional colon tumors about 30 per cent of the time and a substantial number of these will be malignant.[29]

The need to establish whether a villous tumor is benign or malignant is critical. In a retrospective study of 21 malignant villous adenomas, 17 were biopsied and only three were positive, two were doubtful, and 12 were negative.[28] The conclusion, therefore, was that biopsy was worthless. This is not entirely true but it points out the need for careful examination and sound clinical judgment. A shotgun approach with random biopsies from several portions of the tumor usually is unrewarding. The ideal manner to establish the diagnosis is by excisional biopsy of the entire tumor if it is sufficiently small. Otherwise, selective biopsy should be employed. Biopsy specimens should be taken from sites which are firm, indurated, friable or ulcerated. If one's clinical suspicion still is toward cancer despite negative biopsies (on the basis of size, growth rate, personal or family history), it often is wise to treat this as a malignant neoplasm.

In the unusual situation in which the tumor is small, in the lower two-thirds of the rectum, and pedunculated, it may be removed by use of a snare through an operating sigmoidoscope. In the more common situation of a sessile lesion, it may be excised *in situ* after adequate exposure

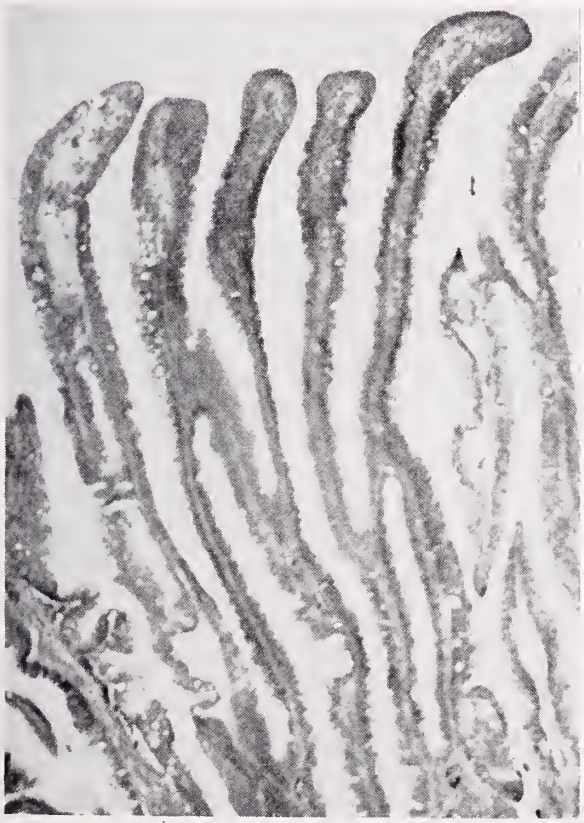

Figure 6. High power view of individual frond-like projections in a villous adenoma.

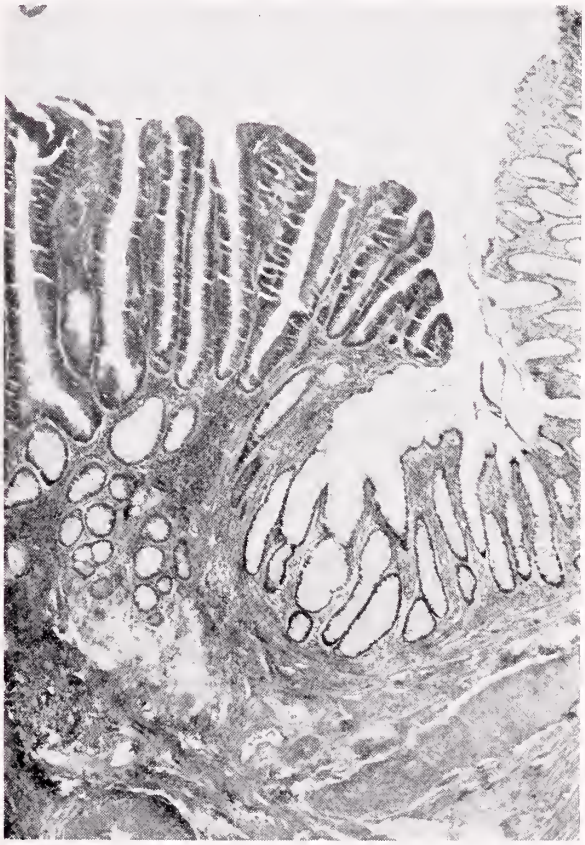

Figure 7. Junction between normal mucous secreting columnar epithelium at right and epithelium of a villous adenoma at left.

with a self-retaining rectal speculum. In this case, the tumor, with a one-half cm. margin of normal appearing mucosa is excised to the muscular layer. Closure should be in a transverse manner in two layers.

Larger sessile villous adenomas of the lower two-thirds of the rectum can be pulled down and delivered outside the anus. The tumor can be re-examined for possible malignancy. An artificial stalk of normal mucosa is created, and can be ligated and excised with the lesion. The danger is that the entire bowel wall may be drawn down as an artificial pedicle and included in the ligature, with subsequent pelvic inflammation resulting. David,[39] in 1943, advocated splitting the anal sphincter posteriorly for large sessile rectal villous adenomas. A modified Lockhart-Mummery[40] posterior approach to the rectum may be necessary to remove a segment of rectum containing a benign tumor too large for local excision. If faced with lower rectal lesions which cannot be adequately handled by any of the previously mentioned methods, one has two choices. It has been said that the benign villous adenoma is an "ideal indication" for the abdomino-anal resection and pull-through operation as described by Bacon in 1956.[41] This procedure must be accompanied by a temporary transverse colostomy, as there is a high incidence of leakage from the sigmoid-anal anastomosis. Occasionally, however, one of these patients may require a Miles[42] A-P resection and permanent colostomy.

For villous adenomas above the peritoneal reflection, a transabdominal sleeve resection is advocated. This is preferred over a colotomy and local excision, as it reduces the chance of contamination and the risk of implantation, without a real increase in morbidity or mortality. The lesion should be examined carefully in the operating room after removal. Suspicious areas and the basal portion should be submitted for frozen section. Anterior resection has been employed for lesions with their lower margins as little as seven cm. from the anus, as a one-half cm. inferior margin of resection probably is sufficient.[28] The need for caution is vividly exemplified in the experience of Wheat and Ackerman.[29] They had a patient with a microscopically benign villous tumor removed by colotomy, only to have her return two years later with an enlarging left rectus mass under her previous laparotomy incision. Local excision revealed another benign papillary tumor similar microscopically to that removed at colotomy.

Diagnosis of malignant villous adenoma may be made by incisional biopsy on permanent or frozen section, or microscopically after excision of a clinically benign lesion. Once the diagnosis is made, the appropriate cancer operation should be carried out.

Careful follow-up of all patients with benign and malignant villous adenomas is necessary. Recurrence is frequent in both groups. Southwood[28] stresses the need for diligent follow-up, but notes that only 11 of 24 local recurrences took place within one year, so long-term reevaluation is very important. Although fulguration is not recommended for the primary care, small local recurrences may be satisfactorily treated by this method. Not to be overlooked in these patients with an unstable epithelium, is an apparent increased incidence of a second, not recurrent, villous adenoma elsewhere in the large bowel.

Summary

The clinical importance and management of four common and important polypoid lesions are outlined. The need for careful examination, attention to detail, sound clinical judgment, reliable histologic evaluation, and individualized therapy and follow-up are stressed.

A list of references may be obtained by writing The Journal.

Discretion in speech is more than eloquence.

BACON

Visual Correction Following Cataract Surgery

James R. Cook, M. D.

Cataracts represent a major visual problem, particularly in patients after the fifth decade of life. There is no known medical treatment for cataracts; they are, however, readily amenable to surgical removal.

There are three major indications for removing a cataract. The first is based on the maturity of the lens itself. If a lens becomes hypermature, it may become swollen, causing secondary glaucoma or may leak proteins from the substance of the lens, causing inflammation (iritis or uveitis) and potentially destroying the eye. Hence, a unilateral mature lens should be removed even with 20/20 vision in the fellow eye.

The second indication for removal of a unilateral cataract of significant severity is to provide binocular vision, a valued ability for those patients engaged in active work, driving, or the operation of mechanical equipment. Extraction of one lens when the fellow eye can see 20/20 may be indicated in the younger age group (50's - 60's) but is rarely carried out in the retired age group, due to the somewhat diminished visual needs of the patient.

The third and most common reason for cataract extraction is to provide better vision. When lens opacities limit the patient's visual efficiency, cataract extraction is considered. Cataracts limiting vision to 20/40, or 20/50 in some patients, would result in significant vision loss if they were actively engaged in activities requiring good vision, e.g., reading, accounting, driving, or other activities requiring discrimination of visual detail. Naturally, the level of vision required for one patient to perform his duties successfully may be quite different from that required by another patient. A farmer, for instance, may function very well with 20/200 vision; whereas an accountant may experience considerable visual disability with 20/40 vision. The exact visual level at which a cataract or cataracts should be removed is a decision which has to be individualized for each patient and discussed between the patient and his physician.

Technically, removal of a cataract is nearly always successful; usual success rates are quoted in the range of 96-98 per cent. Perhaps the real skill involving the cataract patient rests in providing the patient high quality vision following surgery. Good visual efficiency involves not only good visual acuity, i.e., 20/20 on the Snellen chart, but also adequate peripheral vision and patient comfort, tolerance and acceptance.

The Author

- **James R. Cook, M. D., Ophthalmologist, 1616 Thirteenth Avenue, Huntington, West Virginia.**

At this time, vision following cataract surgery can be corrected either with cataract (aphakic) glasses or cataract contact lenses. Contact lenses currently are available as hard lenses, which are ground from ordinary plastic (Lucite or Plexiglass) or a soft contact lens. The soft lens, currently approved by the Food and Drug Administration, is manufactured by the Bausch and Lomb Company under the name of Soflens.® This material is generically polymacron, a hydrophilic (38 per cent water) polymer. The circumstances in which each of these means of visual correction following cataract surgery would be utilized will be described.

Use of Cataract Glasses

Cataract glasses will provide 20/20 central vision in most postoperative cases. They are indicated when both eyes have undergone cataract surgery, especially in the older age group. Cataract glasses can be of help also when one eye has undergone cataract extraction and the other is limited in vision by some sort of eye disease. Cataract glasses are not very helpful when a cataract has been removed from one eye and the other eye has 20/60 vision or better. The reason for this last statement represents one of the most difficult concepts to explain to cataract patients. If a thick cataract lens is placed before an operated eye, the image observed by the patient is magnified about 30 per cent. This magnification is not particularly troublesome to the patient, unless the fellow eye is seeing a normal-sized image through a regular, thin eye-glass. If one eye is seeing an object magnified by 30 per cent, and the other eye sees the same object as its normal size, double vision, or diplopia, will result. Naturally, it would be most confusing for one eye to see an image of a man as six feet tall and the operated eye to see the same man as eight feet tall. A contact lens either of the hard or soft

variety magnifies the image only about five to six per cent, which almost always permits the fusion of a single image with the fellow, unoperated eye.

Further disadvantages of the cataract glasses are in the heavy weight (plastic lenses are preferable to glass for this reason) and their limitation of the peripheral field of vision. A thick cataract eye-glass lens can provide perfect vision when the patient looks through the precise center of the lens; however, vision is greatly distorted through the edges of a thick lens. Patients particularly describe dizziness, difficulty in walking, especially up and down stairs, and hesitancy to drive or even cross streets by themselves because of the poor peripheral vision. Glasses are, on the other hand, less trouble to care for than contact lenses and definitely indicated in the older, more sedentary patient.

Advantages of Contact Lenses

The major advantages of contact lenses include the ability of the contact lens to provide binocular vision when the fellow eye has normal or near-normal vision. The additional major advantage involves the provision of full peripheral vision with the cataract contact lenses. This peripheral vision is most important in active patients, particularly those operating an automobile or other dangerous machinery. A contact lens may be optically helpful in the rare case in which there is considerable corneal astigmatism following cataract surgery. In the cases of patients who can tolerate the extra trouble and inconvenience of inserting and removing contact lenses, visual quality and efficiency are greatly enhanced. A definite medical indication for such lenses exists in contradistinction to the purely cosmetic reason for contact lenses in myopic young girls. There is, to be sure, a major cosmetic advantage to the cataract patient who wears paper thin contact lenses as opposed to thick cataract glasses. In these days of greater awareness of the needs and welfare of our senior citizens, many of these factors take on additional importance. The decision of whether a cataract contact lens or cataract glass is better for a given patient must result from discussion between the patient and his ophthalmologist.

If a contact lens is used in a postoperative cataract patient, it usually is used only to correct distant vision. In that all accommodative ability for near vision is removed when the lens is extracted, the patient is like any advanced presbyope and requires a stronger lens for reading than for distance (a bifocal segment in the glasses). In the cases of patients with cataract contact lenses, a bifocal or half reading glass is nearly always required. The cataract contact lens does not eliminate the need for glasses in these patients but, rather, the contact lens serves to replace the natural crystalline lens removed from the eye due to disease or opacity. These glasses are, however, no thicker than ordinary, every-day glasses.

Cataract glasses may be necessary also in those patients who have been fitted with aphakic contact lenses. Such glasses are necessary to provide the patient with the vision to "find his contacts" and insert them. Glasses are necessary also for emergency use by the patient at times when the contacts are not in the eyes or temporarily lost. Indeed, it is more satisfactory to simply grab a pair of glasses than to insert contact lenses for those unexpected, or even frequent, nocturnal trips. Relatively inexpensive stock or temporary cataract glasses (those not ground especially for the patient) sometimes can be utilized for this purpose.

Choice of Lens Provided

Within the past two years, the ophthalmologist has been provided with a choice as to the kind of contact lens to use for his patient. The traditional kind of hard contact lens is one excellent choice. Its advantages lie in its relatively inexpensive cost, easy cleaning feature, and its ability to correct corneal astigmatism. Many patients can be fitted successfully and comfortably with the hard lens. The major advantages of the soft contact lens are in patient tolerance, comfort and acceptance. The soft lens centers easily on the cornea, is accepted immediately without discomfort by most patients, and can be worn all the waking hours without discomfort or irritation of the eye. The soft lens is less likely to cause any damage to the corneal epithelium of the eye with improper insertion or prolonged wearing. Disadvantages of the soft lens include its greater cost, more cumbersome sterilization techniques, and its inability to fully correct the residual corneal astigmatism. The last named disadvantage is minimized as aphakic contact lens patients are fit with bifocals to correct their near vision anyway, and this residual astigmatism can be readily corrected in these glasses.

As with many medical situations, the visual correction following cataract surgery must be individualized for any given patient. As has been outlined, there are many factors which must be considered for any given aphakic patient to obtain the maximal visual efficiency for his needs. The advent of the new, soft contact lens provides one additional tool for the ophthalmologist in providing effective vision following surgery.

Community Determined Diagnosis

Florence K. Hoback, M. D., and Roy A. Edwards, Jr., M. D.

RECENT books have been presenting presumed causes, precipitating factors and diagnoses of mental illness in various communities. *Social Class and Mental Illness*[1] deals with treatment prevalence in New Haven. A complete census was made of all patients under treatment, both in the hospital or on an out-patient basis; these included private patients of psychiatrists in the town. The principal finding is that the diagnosis and type of treatment which a person receives depends to a great measure upon his social class. Lower social class people are more likely to be called psychotic and hospitalized for somatic treatment. Upper social class people are more likely to be called neurotic and treated with out-patient psychotherapy.

People of Cove and Woodlot,[2] a study of Stirling County, was the first large-scale study of true prevalence. It was done in a rural Canadian community and used the technique of presenting a questionnaire to a sample of the population and judging mental health from the answers. They found much more mental illness than was previously supposed. Prevalence rates of those showing significant impairment from mental disorders are about 20 to 30 per cent and only 17 per cent are completely symptom free.

Mental Health in the Metropolis[3] and *Life Stress and Mental Health*[4] study both true and treatment prevalence of mental disorder. Treated prevalence was determined by a complete treatment census of all hospitals, clinics, psychiatrists and psychologists who might serve people in the area. They found the percentage of the population who are impaired due to mental illness is about 20 per cent. The percentage of the population in whose cases no symptoms of mental disorders at all could be found was 20 per cent; this was similar to those in rural Stirling County.

The cases presented here differ in locale and diagnosis; this presents an interesting contrast between the two. One community seems to support and breed depression while the other seems dominated by schizophrenia. These two communities are within 50 miles of one another. The educational and economic advantages are similar. The patients in both communities were seen by two psychiatrists jointly so that differences in diagnostic criteria should be minimal.

The Authors

- **Florence K. Hoback, M. D., and Roy A. Edwards, Jr., M. D., 1309 Sixteenth Street, Huntington, West Virginia.**

In the last year, treated patients in this psychiatric clinic included persons living within a 100-mile radius in the tri-state area of West Virginia, Kentucky and Ohio.

It is of interest to note that in the one community the major industries are railroad, steel manufacture and farming. In this particular community, the major religions are Baptist and Methodist. Symptoms of patients from this area were sleeplessness, weight loss, feeling of worthlessness, inferiority and suicidal thoughts. Social activities in the area are recreation in state parks, going to church and church-associated activities.

In another community approximately 50 miles into the hills, the symptomatology was altogether different; fear, hallucinations (several of dogs barking and howling in the night), delusions, religious preoccupation and subjective and objective signs of schizophrenia. The major industry in this area is coal mining. Religious denomination is Jehovah's Witnesses or Catholic. These people spend a good deal of their leisure time in beer parlors. The outlook of this segment is more violent than that of the other group; they see most situations on a life and death basis, and one of this group had been involved in a murder. These people are within the Bible Belt and see everything as right or wrong, black or white. They are very uncompromising in their attitudes.

What is there about an area that causes the inhabitants to take on a depressive mood? Your eyes tell you here are about 7,000 people spread out on green hills and gentle valleys in $20,000 homes, all built in the last 10 years. There are roses blooming, little or no air pollution, a clean, clear sky, away from major industry but close enough to industry to afford a good income for the inhabitant.

In the other community their entire life is dependent upon the mine, its whole life revolves around the routine of the whistles, the shifts,

the trains, and the tipple. The whole community dances to the tune of the coal company, tempered by the effects of United Mine Workers organizations.[5] Of the population here, approximately 18 per cent have been seen by a psychiatrist (266 are included in this report), about 8 per cent greater than average, as given by Noyes,[5] but similar to the *People of Cove and Woodlot*. Of this 18 per cent, about 75 per cent or 200 have a depressive neurosis, 5 per cent or 13 alcoholic, 5 per cent or 13 anxiety neurosis, 5 per cent or 13 phobic, 5 per cent or 13 schizophrenia, paranoid type, and 5 per cent or 14 chronic brain syndrome on an atherosclerotic basis. Sexual division was 55 per cent or 146 female and 45 per cent or 120 male. Forty per cent or 48 of the men worked on the railroad. 50 per cent or 60 men worked for a steel company, and 10 per cent or 12 were farmers. All of the females were housewives.

Mazer[6] gives a number of patients with psychiatric disorder as 12 per cent.

Psychiatric Disorders		*Male*	*Female*
Psychoneurotic disorders	49.6%	39.5%	56.0%
Psychophysiologic disorders	30.1%	32.5%	28.6%
Personality disorders	7.1%	12.3%	3.9%
Chronic brain disorders	6.1%	8.8%	4.4%
Transient situational personality disorders	3.7%	3.7%	3.9%
Psychotic disorders	2.4%	3.5%	1.7%
Mental deficiency	1.0%	0%	1.7%

Twelve per cent of the population consulted physicians because of psychiatric problems.

Silverman[7] in the epidemiology of depression gave the prevalence note for depressive psychosis as being less than one per 1,000 population. Paykel[8] gave precipitating factors of depressive neurosis as:

Increased arguments with spouse
Marital separation
New type of work started
Change in work conditions
Serious personal illness
Death in immediate family
Serious illness of family member
Family member leaves home
Moves
New person in home
Major financial problems
Pregnancy
Unemployment
Court appearance
Childbirth
Lawsuit

Why is the community so inflicted with a depressive attitude? Is it political? Hardly. They are about equally divided Republicans and Democrats. Religion-Methodist, Baptist, Presbyterian and Church of God. Recreation—state parks (two in area,) with swimming, boating, picnicking, horseback riding and other family activity. They have a skating rink, no obvious beer joints or taverns, no Woman's Clubs or Men's Lodges. There is a VFW Hall. The area is dry as far as purchasing alcohol is concerned.

Typical patient: White female, age 32, married 14 years, three children. Husband is plant employed. Patient works part time on the psychiatric unit in a nearby city hospital. Hospitalized when husband accused her of being unfaithful. Patient denies this. She has suffered from sleeplessness, loss of appetite, weight loss, suicidal thoughts; and she gave a history of overdose of medication in the past. Family history: Mother died when the patient was 12. Father is living and well; father has an alcohol problem, and has been hospitalized for treatment. Patient is quite sensitive about any drinking. One brother, living and well, lives in another state. Patient has considered suing for divorce but fears she can't support herself. She has a seventh grade education and no occupational skill. Physically she is in good health, slightly overweight. Patient received Triavil and electroshock therapy; marked improvement was noted.

The other community—population almost identical. Less than 10 per cent of the population or 244 people are emotionally ill, with 20 per cent or 49 alcoholic, 10 per cent or 24 depressive neurosis, and 70 per cent or 171 schizophrenic. Home and incomes are essentially the same as in the other community; 85 per cent or 94 were miners, 15 per cent or 16 were clerks, postoffice employees, and farmers. The community was set between two hills. It was as if the hills were pushing in on the population. The oppressive thoughts of the hills caving in—the miner's curse.

Typical patient: White female, age 37, married at age 17 to a miner 13 years her senior. Husband beat her and injured her back. Patient was first hospitalized for backache.

Patient was depressed and delusional. She felt people were talking against her. She had been brought to court by a neighbor for slander. Patient saw and heard dogs barking at night, but she had never found the dogs during daylight hours. She has three children, a 14-year-old son, 12-year-old daughter, and a 6-year-old son. Her father and mother are living and well. She has two brothers and two sisters living and well. She is unable to do her own housework. Patient tried to perform an abortion on herself with a catheter and laxative when she found she was pregnant with her last son; she has considerable guilt feelings concerning this. Her husband

killed a neighbor who was drunk and tried to enter their home because of fighting between her children and the neighbor's children; her husband was acquitted.

Physically, this patient has a constricted urethra, endometriosis and a fused spine from disc surgery. Patient belongs to Jehovah's Witnesses. She has a high school education. Diagnosis: Paranoid schizophrenia. Treated with Mellaril and psychotherapy. Prognosis is poor.

This patient lives in a much more isolated area surrounding her town. The hills are higher and the valleys deeper than those of the other community. The area is filled with lawful and unlawful alcohol; the valleys are filled with stills, and the blue smoke curls up from one just over the hill from her home. This particular still belongs to a friend of her husband whom the patient blames for many of her husband's faults. This patient states she never was allowed to be free—to enjoy her teenage. She was married at 17. Her bitterness is almost as intolerable as her paranoid thinking. She hates with a passion. She rules her home and her sick-thinking rules her home. She states one of her doctors tried to rape her and another made her a drug addict. She has some addiction to Percodan.

Both communities were cursed with the repeated intermarriage of cousins; no chance for upgrading the mentality. The changing role of male and female is having a profound effect on the folk culture; as the mountain man has been more and more eliminated from the job market, his strength being no longer needed, the mountain woman has found her place in hospitals as practical nurse, in assembly plants where her nimble fingers have given her an advantage over her less social husband.

This case does not (nor does any other from this community) show the symptoms of isolation described in Gunderson's[9] article, who lists symptoms as:

Sleep disturbance
- difficulty falling asleep
- waking during night

Depression
- blue, lonely, feeling people were watching or talking about them
- preferring to be alone

Aggression
- feeling easily annoyed
- feeling critical of others
- feeling others short-tempered
- burning up with anger

Anxiety
- somatic complaints
- headaches
- heart pain
- backache
- nausea
- itching

What is it about these communities that determines the emotional climate of the inhabitant? The schizophrenic leads a much more violent life, exposed to the sudden death of the miner; her personality is more explosive—as if sitting on a powder keg. But what of the quiet isolated hamlet? Is depression born from boredom?

Most rare cases? No, these are merely two of hundreds of patients seen in the clinic daily practice. Complete battery of psychological tests were given these patients; these test results and clinical impressions were similar, and usually the same. No adequate explanation of the diagnostic distribution is evident.

On visiting the two communities as a casual observer, one cannot but feel more depressed in the coal mining community. Then why the excessive number of patients with diagnosis of depressive neurosis in the other community? No answer is obvious to us.

A list of references may be obtained by writing The Journal.

Abnormalities of Nerve Cells

STRONG evidence that abnormalities of nerve cells are present in patients with severe mental illness is reported by University of Chicago investigators. They demonstrated abnormalities in nerves connecting skeletal muscle to the spinal cord in 16 of 24 psychotic patients. Changes comparable to those found might also be occurring in the brain and spinal cord and be related to the cause of psychosis itself, they said.

The irritations of man's day are often reflected in his gut.
The causes of irritable colon and the diarrheal symptoms that often accompany it can be as diverse as the systemic and emotional irritations man is faced with daily.
Although the mucoid nature of stools and the occurrence of diarrheal episodes coincident with times of emotional stress may be valuable clues to the functional nature of the disorder, irritable colon must often be diagnosed by exclusion. Such diagnostic exploration takes time. Discovery of the nature of any emotional problems may take more. During that time, Lomotil® is an ideal agent for controlling diarrheal symptoms.
Lomotil tablets are small, easy to carry and easy to take. They act promptly and effectively. Secondary effects are relatively infrequent and, once the first force of the diarrhea is controlled, maintenance is frequently effective on as little as one fourth of the initial dosage.
These same characteristics make Lomotil useful in controlling the diarrhea associated with gastroenteritis, antibiotic therapy and acute infections.

Lomotil®

TABLETS/LIQUID

Each tablet and each 5 ml. of liquid contain:
diphenoxylate hydrochloride . . . 2.5 mg.
(Warning: May be habit forming)
atropine sulfate . . . . . 0.025 mg.

takes care of the gut issue in irritable colon

IMPORTANT INFORMATION: *This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.*

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria and paralytic ileus.

Dosage and administration: ***Lomotil is contraindicated in children less than 2 years old.*** Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. *Liquid,* 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

SEARLE **Searle & Co.**
San Juan, Puerto Rico 00936

Address medical inquiries to:
G. D. Searle & Co., Medical Department
Box 5110, Chicago, Illinois 60680

With the means at hand to drastically reduce the number of deaths each year from uterine cancer, we have embarked on a nationwide, life-saving program. Its goal is a Pap test by 1976 for every woman 20 years or older to whom the test is applicable, and for younger women at risk. An ambitious program, doctor, and one which can only be realized with your help.

We are faced with these facts: only 53% of women over 20 have ever had a Pap test; only 20% get a Pap test periodically; each year about 43,000 new cases are diagnosed; this year 12,000 women in this country will die of uterine cancer. And about 75% of these deaths will result from cervical cancer — as you know, almost 100% curable when diagnosed early and treated promptly.

We hope to reach women in the target group not only with the message about the *vital* Pap test, but also with the urgency of including it in the *regular* health checkup. The mortality rate from uterine cancer could thus be dramatically curtailed.

Clearly action is called for. Coordinated action — involving the doctor, the patient, the American Cancer Society — a partnership for life.

a partnership for life

American Cancer Society

WEST VIRGINIA DIVISION, INC.
325 Professional Building
Charleston, West Virginia

THIS SPACE CONTRIBUTED BY THE PUBLISHER AS A PUBLIC SERVICE

A Continuing Medical Education Special!

Such sponsors and participants as the West Virginia State Medical Association; its Section on Urology; West Virginia Chapter, American Academy of Pediatrics and the Department of Pediatrics, Charleston Area Medical Center; West Virginia Division, American Cancer Society; West Virginia Diabetes Association; West Virginia Thoracic Society; American Heart Association, West Virginia Affiliate; West Virginia Tuberculosis and Respiratory Disease Association; West Virginia University School of Medicine and Alumni Association; West Virginia State Health Department; West Virginia Chapter of the Arthritis Foundation and Woman's Auxiliary to the Kanawha Medical Society.

are pleased to announce

"The Seventh Mid-Winter Clinical Conference"

at the

Heart-O-Town Motor Inn
Washington and Broad Streets
Charleston, West Virginia

8 P.M. Friday, January 18
10 A.M. and 1:30 P.M. Saturday, January 19
10 A.M. and 1:30 P.M. Sunday, January 20

THE PROGRAM again will offer a wide-ranging clinical and educational experience for the practicing physician. FRIDAY EVENING, JANUARY 18, presentations will include Professional Standards Review Organizations (PSROs) and a session open to the public on the "battered child." A medically oriented battered child program will follow SATURDAY MORNING, JANUARY 19, with these other scheduled subject areas: SATURDAY AFTERNOON, asthma, diabetes, heart disease and hypertension, diuretic management; SUNDAY MORNING, JANUARY 20, cancer chemotherapy, antimicrobial therapy and arthritis; and SUNDAY AFTERNOON, obstetrics and gynecology, urology and chemotherapy of the venereal diseases.

THE FACULTY will include outstanding specialists in their fields from various educational and other settings, both outside and from within West Virginia.

THE PROGRAM CO-CHAIRMEN again are Ralph H. Nestmann, M.D., and Joseph T. Skaggs, M.D., both of Charleston.

THE REGISTRATION FEE of $15 for the entire conference will be charged all registrants except nurses, medical students, interns and residents; and will include admission to a group buffet luncheon on Sunday, January 20. Advance registration is requested, and please make checks payable to "WEST VIRGINIA STATE MEDICAL ASSOCIATION."

ACCREDITATION: Attendance will be acceptable for credit toward the Physician's Recognition Award of the American Medical Association; and the program also is expected to carry prescribed credit by the American Academy of Family Physicians.

OVERNIGHT ACCOMMODATIONS: Physicians planning to spend one or more nights in Charleston should communicate directly with the reservation manager of the hotel or motor inn of their choice, with the conference headquarters inn setting aside rooms for registrants.

FOR ADVANCE REGISTRATION, please complete the form below and mail to: WEST VIRGINIA STATE MEDICAL ASSOCIATION, P. O. BOX 1031, CHARLESTON, W. Va. 25324.

Please register me for the Seventh Mid-Winter Clinical Conference in Charleston, W. Va., January 18-20, 1974. My $15 registration fee is (is not) enclosed.

I will attend sessions at 8 P.M. Friday, January 18 ..... 10 A.M. Saturday, January 19 ....., 1:30 P.M. Saturday ..... 10 A.M. Sunday, January 20 ..... 1:30 P.M. Sunday ..... all sessions .....

Name (please print) _____ *Specialty* _____

Address _____ *City* _____

A message from . . .

The President

BACK TO BUSINESS!

THE holiday season with all its beautiful trimmings and wonderful family togetherness is behind us. Now we must look forward to the months immediately ahead which will be filled with many activities directly affecting every member of the West Virginia State Medical Association.

We must be alert to the fact that the members of the State Legislature will gather in Charleston early this month for the regular 60-day session. At this point, we don't know how practicing physicians will be affected by bills placed in the hopper—but please take time to talk with your elected representatives concerning any bills in which we have an interest. Discussion on the grassroots level is much more effective than last minute and hurried conferences in the hallways of the Capitol in Charleston.

Continuing medical education is a must! Make it a point to attend the Seventh Annual Mid-Winter Clinical Conference in Charleston January 18-20. Drs. Ralph Nestmann and Joe Skaggs—along with a number of other interested individuals and organizations—deserve much credit for making this scientific program an ideal way to keep abreast of modern advances in the practice of medicine.

Even with the snow on the ground, it is not too early to send in your reservation form for the 107th Annual Meeting at The Greenbrier in August. The scientific program has been completed and the names of the speakers will be publicized in future issues of *The Journal.* I can't imagine a better place to combine the best in continuing medical education and recreation than at this marvelous resort hotel. Don't forget—the Program Committee has ruled there will be no afternoon scientific sessions—but your morning hours will be occupied in absorbing the best there is to offer in postgraduate medical education.

Therefore, shake the snow off your boots and prepare for a busy year ahead. We hope to intersperse some fun with the many serious problems during a period which no doubt will prove crucial to all of us in the practice of medicine.

Tom McCoy

A. THOMAS MCCOY, M. D., *President*

THE WEST VIRGINIA MEDICAL JOURNAL

Official Organ of the West Virginia State Medical Association

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Editor
GEORGE F. EVANS, M. D.
122 South Sixth St.
Clarksburg, W. Va.

Managing Editor and
Business Manager
MR. WILLIAM H. LIVELY
Box 1031
Charleston, W. Va. 25324

Associate Editors:
VERNON E. DUCKWALL, M. D.
Elkins
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EDITORIALS

MORTALITY AMONG PHYSICIANS

There is a general belief, presumably because of long hours of work, often under stressful conditions, that physicians have a life expectancy shorter than that of the general population. Three rather extensive studies have been reported on deaths of physicians which occurred during the years 1925, from 1938 to 1942, and from 1949 to 1951. The study covering the years between 1938 and 1942 showed that the mortality of physicians is about the same as that of white males in the general population. The other two studies suggested that the life span of physicians is considerably longer than the average white male.

More recently, Williams et al.[1] reported a cohort study (the first of its kind on physician mortality) on nine classes from the Harvard Medical School roughly at ten-year intervals; 1923-1924, 1932-1934 and 1942-1944 (two classes were graduated in 1943). In essence, their findings confirmed work reported during 1925 and from 1949 to 1951, namely that physicians live somewhat longer than other groups in the general population. The present study was done almost exclusively on specialists, but the authors point out that this is not an important factor since no difference could be demonstrated when this study group was compared with the total population of physicians.

Although the causes of death were not determined particularly in this group, it was emphasized that previous reports have shown that the leading cause of death in the physicians' population is diseases of the heart, particularly coronary artery disease. In fact, death from heart disease is more common in the physician population than in control population of white males. There are two other conditions which produce death more frequently in physicians than in other people—namely diabetes mellitus and suicide. The latter accounts for from one to three per cent of the total number of physicians' deaths.

It is also mentioned in this article that on the whole physicians work longer than other professional groups. Data obtained from the 1960 Census of the United States population showed that physicians and surgeons work 48.2 weeks during the year, while the other professional groups worked an average of 44.5 weeks. Another figure is significant: in 1965, office-oriented physicians estimated they practiced 55.8 hours a week.

The fact that the life span of physicians exceeds that of the average layman is somewhat surprising, for they work long hours and the nature of their work often makes significant emotional demands. The authors suggest several reasons to account for the increased longevity of

physicians. One factor stressed is that the highly selective process of medical schools admits previously healthy individuals from the middle and upper socioeconomic class to the medical profession. Another factor is that the competitive academic training for the M. D. degree effectively prevents many of those who are in poor health from becoming a physician. Furthermore, as students in college and in medical school the pre-medical and medical students probably receive better medical care than the general population for many institutions of higher learning maintain excellent student health care programs. Later, when the student becomes a member of the medical profession, he has easy access to the effective therapeutic measures which his profession can offer. It is emphasized, however, that many physicians do not always take advantage of this latter situation.

All of the above suggestions are pertinent and presumably sum up fairly well the possible reasons why physicians live somewhat longer than the average layman. It is possible of course that there may be still other factors.

1. Williams, S. V. et al. J. Chronic Diseases 24:393, 1971.

Physicians Urged to Help Parents In S.I.D.S. Tragedy

Suddenly, and silently, a baby dies in his bed, for no apparent reason. When they find him, the parents reel under an ordeal of not only grief, but uncertainty. Was it their fault? Should they have watched the child more closely? How could it have happened? Unfortunately, reassurance and support for them are often lacking, and their uncertainty is never resolved, says Dr. Abraham B. Bergman of Seattle.

The mysterious disease, Sudden Infant Death Syndrome, kills about 8,000 infants a year in the United States. So far, there is no way to prevent the tragic occurrence. But, Doctor Bergman said, the second tragedy—that of emotionally battered parents—*can* be prevented or greatly relieved with help of an understanding and compassionate physician, and public officials.

Doctor Bergman, president of the National Foundation for Sudden Infant Death, Inc., spoke recently to the American Academy of Pediatrics, meeting in Chicago. Although the cause of SIDS, also known as "crib death," remains unknown, he said, a great deal of data has been collected.

In just the last decade, crib death has been established as a distinct disease. "Secondly, a whole host of possible etiologic (cause) theories were effectively disproven, among them being allergic, traumatic and toxic causes. Lastly, viral upper respiratory agents were generally recognized as playing some role in the majority of cases."

This also is known, he said:

—SIDS is more likely to occur in males, of low birth weight, in low socio-economic class families (although it happens in all families) and during seasons of upper respiratory illness. It is uncommon before two weeks and after six months of age, with peak incidence between two and three months of age.

—The victims seem typical of the entire population of that age group. "There are fat ones, thin ones, unkempt ones, immaculate ones—all kinds," Doctor Bergman said. "About half of them have symptoms of a cold in the week before death." Virtually all die during sleep, and silently.

The bed clothes are usually in disarray and there are other signs that the infant died in a turbulent manner, as in a sudden spasm struggling for breath.

Much research is proposed and going on into crib death, some of which will take years and much money to complete, but which is "crucial if we wish to gain a true understanding of SIDS," Doctor Bergman said.

More immediate good can be done in relieving the agony, and sometimes suspicious hostility, facing the parents of the child, he said.

In doing early research on SIDS, the physician said, "I learned a few more things, like the destruction of families from needless guilt, and the callousness of the medical profession, myself included, for allowing such an enormous amount of psychiatric morbidity (illness) to fester without lending a helping hand.

"Very simply, though the disease can't be prevented, the attendant guilt reactions in surviving family members *can* be prevented through proper management. A physician has few opportunities to accomplish more in the way of preventive psychiatry than when faced with a case of SIDS. Of course, all families suffer tremendous grief when their child dies of SIDS, but if an informed and compassionate physician is at their side, the pain will diminish and they will go on living. If they are left to suffer in ignorance and guilt, the results are devastating, and in many cases cause permanent emotional damage."

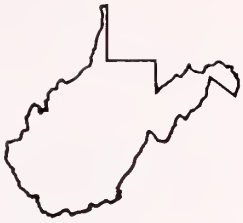
These are some of the reasons such support for the families is badly needed, Doctor Bergman said, as revealed by a survey of 158 communities:

—Autopsies were routinely performed in sudden infant deaths in only 25 per cent of the communities and only when a crime was suspected in 20 per cent. In the others, it "depended on available funds and how hard the family and private physician pushed for an autopsy."

—The person certifying the cause of death was not even a physician in 43 per cent of the communities (thus to him *all* deaths were a mystery).

—Although "it is heartless to keep families in the agony of suspense waiting to learn why their baby has died," only 39 per cent of families got autopsy results in less than a week. Others got them in from under a month to under three months, but 9 per cent never got them at all.

GENERAL NEWS



PSRO Discussion To Launch Mid-Winter Conference

A practical discussion of what Professional Standards Review Organization (PSRO) activities likely will mean to the physician in his day-to-day practice will be a feature of the January 18-20 Mid-Winter Clinical Conference at Charleston's Heart O' Town Motor Inn.

The PSRO workshop will be held at 8 P.M. on Friday, January 18, and will be led by one who has "been there" in development of closely related programs — Executive Administrator E. David Buchanan of the Utah Professional Review Organization (UPRO).

Paul J. Wiesner, M.D.

Also on the Friday night program is a session, to be open to the public, on "The Battered Child," with speakers to include physicians, a school psychologist, an assistant Kanawha County prosecuting attorney and a West Virginia Department of Welfare representative.

Beginning on Saturday morning, January 19, the Conference will offer a wide range of clinical topics with particular emphasis on drug therapy. The program will have 11 principal speakers, with ample time for questions and group discussions.

"The suggestion that the PSRO meeting emphasize a give-and-take between myself and the audience, and among the audience itself, is entirely consistent with my views," Mr. Buchanan observed in accepting an invitation to participate in the January 18 program. He added:

"I'll be able to suggest answers to many questions based on our experience (with professional review) in Utah, but I think the meeting will be more productive and useful if it helps your physicians to decide for themselves what the answers ought to be in West Virginia."

Mr. Buchanan has held additional UPRO responsibilities as Director for an Experimental Medical Care Review Organization (EMCRO) project carried out in Utah from May, 1972, to the present with a special grant from the U. S. Bureau for Health Services Research and Evaluation.

He currently is a member of both the PSRO Task Force on Rules and Regulations of the American Medical Association, and the Joint Task Force on PSRO of the American Association of Medical Society Executives and the AMA.

From 1968 to 1972, Mr. Buchanan was Director of the AMA's Department of Health Care Financing; and prior to 1968, he spent 10 years in various positions in the commercial health insurance industry.

He served as managing editor and shared authorship of the *Peer Review Manual* published by the AMA.

Another of the Conference's speakers, addressing himself to "Current Chemotherapy of the Venereal Diseases" on the Sunday afternoon, January 20, program will be Paul J. Wiesner, M.D. He is Chief of the Operational Research Section, Venereal Disease Branch, Bureau of State Services, at the U. S. Center for Disease Control in Atlanta.

Doctor Wiesner received undergraduate and medical degrees from the University of Wisconsin in 1963 and 1967, respectively, and is a native of Wausau in that state. He won Phi Beta Kappa honors as an undergraduate, and also is a member of Alpha Omega Alpha.

Doctor Wiesner served an internship and his residency at Strong Memorial Hospital in Rochester, New York; and is a Diplomate of the American Board of Internal Medicine.

Physicians who have not pre-registered for the Clinical Conference still may do so by using the form provided them in an earlier mailing; or by completing the same form printed elsewhere in this issue of *The Journal*.

The conference is approved for credit toward the Physician's Recognition Award of the American Medical Association; and for 12 hours of elective credit by the American Academy of Family Physicians.

West Virginia PSRO Area

The Medical Journal learned just before going to press that Federal officials have designated West Virginia as a single Professional Standards Review Organization (PSRO) area under provisions of a 1972 Congressional enactment.

Medicaid Program Broadened To Medically Needy

West Virginia's Medicaid Program administered by the Department of Welfare has been broadened, effective this month, to include additional state residents classified as "medically needy."

Since July 1, 1966, the program has provided medical coverage for those individuals receiving money payments from the welfare agency, and thus has primarily embraced those on the public assistance rolls.

Under the expansion, individuals and families who meet eligibility requirements for a money payment except for income now will be covered. Persons in this group are able to provide for their food, clothing and shelter—but do not have sufficient resources to pay for their medical care.

The Department of Welfare's Division of Medical Care will be distributing to physicians and other providers under the Medicaid Program further specific details about the broadened coverage.

Those now eligible will apply at welfare offices in their counties of residence; and will be issued identification cards each month containing certificate numbers, initials and birthdates of those eligible, along with periods of eligibility.

The Department has explained that program benefits will be the same for the new group as for other eligible recipients—and program coverage and billing procedures will remain unchanged.

The period of Medicaid eligibility for the new group generally will be from the first to the last day of the current month. There will, however, be some exceptions to this general rule.

For example, Medicaid coverage will be extended up to three months prior to application for all eligible recipients. This means that the initial Medicaid card for this group may reflect more than one month's coverage prior to the current month.

Also, Medicaid coverage for medically needy "spend-downers" will begin on specific days in a month, and initial cards for this group of eligibles will show days, months and years.

"Spend-downers" are individuals and families who may not be initially eligible for Medicaid because their income exceeds the medically needy eligibility standards. These persons, however, may become eligible after application by incurring medical expenses which equal or exceed their excess income, in a process called "spend-down."

Vietnam Program Terminated

A program in which American doctors voluntarily served South Vietnamese civilians during the war there has been terminated. The American Medical Association's Physicians for Vietnam Program operated for eight years. A total of 774 physicians served 1,029 tours of duty, 60 days long, in provincial or civilian hospitals. One hundred and thirty-six doctors served more than one tour, and some went back four or five times.

Four-Year Approval Granted Association CME Program

The West Virginia State Medical Association's accreditation program for continuing medical education has been granted full approval for a four-year period.

The approval was announced by the Council on Medical Education of the American Medical Association after it reviewed the program's activities during a one-year provisional period.

The Council also has approved provisional certification, for one year, of a developing continuing medical education program at the Beckley Appalachian Regional Hospital.

The AMA unit's action followed a recommendation from the State Medical Association and its Committee on Medical Education and Hospitals after a survey, including an on-site visit by a survey team, at the hospital.

New Corporation To Support Asthmatic Youth Effort

Allergy Rehabilitation Foundation, Inc., of Charleston has announced the formation of a new non-profit West Virginia corporation to assist in educational and fund raising activities centered about a summer camping program for asthmatic children.

The Foundation operates the camp, Bronco Junction, which each year draws children, staff personnel and volunteer physicians/consultants from various parts of the nation to the Putnam County site.

Foundation officials said that the new corporation, Bronco World, Inc., will have among its objectives the development of regional and local chapters throughout the United States and elsewhere to support the summer camp.

Dr. Harry S. Weeks, Jr., of Wheeling, President of the new West Virginia Medical Institute, Inc., was an intent observer at sessions devoted to the new Professional Standards Review Organization (PSRO) statute during the American Medical Association's December 2-5 Clinical Convention at Anaheim, California. Doctor Weeks (left) is shown above with Mr. John W. Pompelli of Chicago, a member of the American College of Surgeons staff; and Dr. Henry Simmons, currently heading the Office of Professional Standards Review (OPSR) in the U. S. Department of Health, Education and Welfare in Washington, D. C. The Medical Institute expects to seek an HEW contract to implement PSRO in West Virginia once necessary Federal guidelines for such a step are provided.

Dr. Richard W. Corbitt, left, of Parkersburg chats with American Broadcasting Company sportscaster Frank Gifford, who addressed a luncheon during the 15th National Conference on Medical Aspects of Sports at Anaheim, California, December 1. Doctor Corbitt presided at the Conference in his role as Chairman of the American Medical Association's Committee on Medical Aspects of Sports. The Conference was held just prior to the AMA's annual Clinical Convention.

Charleston Meeting To Review Malpractice Problems

A panel of attorneys will discuss malpractice problems facing physicians and hospitals during a special program to be held in Charleston on Saturday, January 26.

The program, to run from 8 to 10 A.M., has been arranged by the medical staff of Charleston Area Medical Center, and will be held in Room 101 of the administration building at CAMC's General Division.

Charleston attorney David D. Johnson will moderate the discussion. The CAMC staff said that all physicians and hospital administrators are invited to attend.

Student from Kanawha County Newest NYLIC Scholar

The newest NYLIC (New York Life Insurance Company) scholar at the West Virginia University School of Medicine is Jerry W. Froelich, a first-year student and son of Mrs. Helen A. Froelich of Cabin Creek, Kanawha County. WVU is one of 12 schools in the United States and Canada the company selected for the program, begun in 1966, which covers tuition, books, room, board, fees and equipment for one student in each of four classes.

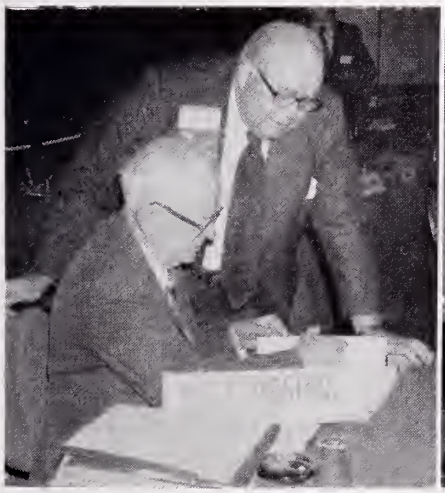
Jerry W. Froelich

Other WVU NYLIC scholars are Curtis A. Chambers, a senior, and Robert W. Rectenwald II, a junior, both of Charleston, and Thomas Csencsitz, a sophomore from Morgantown.

Doctor Hoffman Honored By Surgeons' Section

Dr. C. A. (Carl) Hoffman of Huntington, immediate Past President of the American Medical Association, has received an honorary degree representing the highest award bestowed by the United States Section of the International College of Surgeons.

Doctor Hoffman was honored during an annual convocation in Chicago in November. He addressed the organization on "International Aspects of Malpractice" in his role as Chairman of a new U.S. organization, the Medical Liability Commission.



West Virginia's two Delegates, Drs. Frank J. Holroyd of Princeton (seated) and Dr. Richard E. Flood of Weirton, compare notes in the left photo above before a meeting of the House of Delegates at the American Medical Association's Clinical Convention December 2-5 in Anaheim, California. In the center photo, Dr. C. A. (Carl) Hoffman (right) of Huntington, Immediate Past President of the AMA, is shown with Dr. E. Bryce Robinson, Jr., of Birmingham, Alabama, AMA Vice President, and Dr. John H. Budd of Cleveland, Ohio, an AMA Trustee. At the right is Dr. Russell B. Roth, the AMA President from Erie, Pennsylvania.

Fourteen Receive Certificates After Paramedic Course

Fourteen members of the Southern West Virginia Regional Health Council's Emergency Care Program have been certified by the Medical Licensing Board of West Virginia to serve as paramedics.

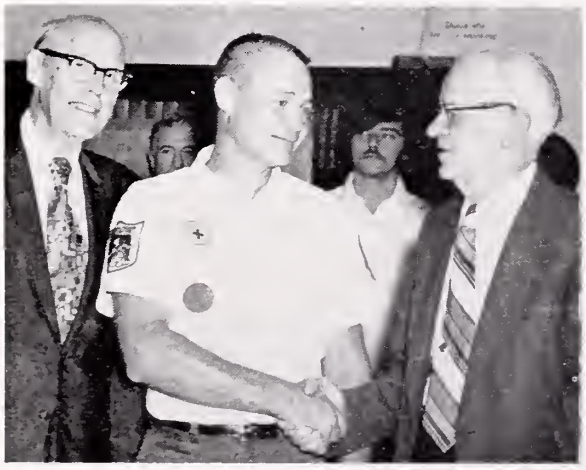
Dr. N. H. Dyer, West Virginia's Director of Health, said that the 14 completed the curriculum required for certification in a pilot program he termed very successful.

The new graduates can, when in voice communication with a physician, administer certain medications and initiate intravenous therapy. They may defibrillate pulseless patients without voice contact.

Doctor Dyer said that other courses in the paramedic training program were under way in Charleston, Elkins and West Union. Additional ones are anticipated in Parkersburg, Clarksburg, Morgantown, Philippi and Beckley.

Over the past two years, Doctor Dyer added, more than 2,000 persons have completed the 81-hour basic Emergency Medical Technicians (EMT) Course offered in the state. They have included personnel from volunteer ambulance organizations, private ambulance providers and non-profit ambulance organizations.

Currently, the Office of Emergency Health Services is conducting 15 EMT training programs in various parts of the state.



The State's first mobile intensive care paramedic, Dave Harman (center) of Princeton, receives congratulations from Frank J. Holroyd, M.D. (right), Chairman of the Medical Licensing Board of West Virginia and also a Princeton resident. Looking on at the left is N. H. Dyer, M.D., M.P.H., Director of the West Virginia Department of Health. Harman, a former military service medic, is employed by the Emergency Care Program of the Southern West Virginia Regional Health Council, an ageney which conducts a comprehensive health care program in nine counties in Southern West Virginia.

Dr. Thomas P. Long Cited

The Logan County Chapter of the American Red Cross has cited Dr. Thomas P. Long of Man as a "prime example of compassion in action" for his service during the February, 1972, Buffalo Creek flood disaster in which 125 persons died.

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled in the coming months.

1974

Jan. 6-8—Soc. of Gyn. Oncol., Key Biscayne, Fla.
Jan. 18-20—Mid-Winter Clinical Conf., Charleston.
Jan. 19-23—Am. Acad. Allergy, Bal Harbour, Fla.
Jan. 19-24—Am. Acad. Ortho. Surgeons, Dallas.
Jan. 20-24—James C. Kimbrough Urol. Sem., Silver Spring, Md.
Jan. 21-23—Hemophilia (N. Y. Acad. of Sciences & Natl. Hemo. Found.) N. Y.
Jan. 25-27—So. Rad. Conf., Point Clear, Ala.
Jan. 25-27—AMA Natl. Leadership Conf., Chicago.
Jan. 28-30—Soc. of Thoracic Surgeons, L. A.
Feb. 1-3—AMA Council on Med. Educat. Congress, Chicago.
Feb. 10-16—Am. Soc. of Contemp. Ophthal., Miami Beach.
Feb. 10-16—Am. Soc. of Contemp. Med. & Surg., Miami Beach.
Feb. 11-14—Am. Coll. Card., N. Y.
Feb. 13-16—National Assn. Med. Examiners, Dallas.
Feb. 14-16—Soc. Univ. Surgeons, St. Louis.
Feb. 24-28—Med. Soc. State of N. Y., N. Y. City.
Mar. 1-3—Student Am. Med. Assn., Dallas.
Mar. 7-9—Central Surg. Assn., Cincy.
Mar. 15-17—AMA-AMPAC Pub. Affairs Workshop Washington, D. C.
Mar. 22-23—Am. Assn. of Ob.-Gyn., Los Angeles.
Mar. 24-25—Am. Soc. Clinical Pharmacology and Therapeutics, Maui, Hawaii (San Francisco, Mar. 28-29).
Mar. 25-27—Am. Coll. Surgeons, Houston.
Mar. 28-29—Am. Bd. Med. Specialties, Chicago.
Mar. 29-April 3—Am. Soc. Abdom. Surgeons, Las Vegas.
Mar. 31—April 5—Am. Coll. Physicians, N. Y.
April 1-5—Am. Coll. of Rad., New Orleans.
April 5-7—W. Va. Chapter, AAFP, Charleston.
April 17-19—Maryland Medical, Baltimore.
April 17-20—W. Va. Acad. of Ophth. and Otol., White Sulphur Springs.
April 20-25—Am. Assn. of Neur. Surg., St. Louis.
April 22-24—Am. Assn. Thoracic Surgery, Las Vegas.
April 22-25—Am. Acad. Pediatrics, Bal Harbour, Fla.
April 22-27—Am. Acad. of Neur., San Francisco.
April 29-May 2—Am. Coll. Ob.—Gyn., Las Vegas.
May 1-3—Am. Surg. Assn., Colorado Springs.
May 1-4—W. Va. Chapter, ACS, White Sulphur Springs.
May 12-15—Am. Thoracic Soc., Cincy.
May 12-15—S. Carolina Med. Assn., Myrtle Beach.
May 12-15—Ohio State Med. Assn., Cleveland.
May 12-16—Am. Assn. Plastic Surgeons, Seattle.
May 16-18—Childhood Cancer, Dallas.
May 17-18—Am. Assn. Clin. Urologists, St. Louis.
May 19-22—Am. Ophthal. Soc., Hot Springs, Va.
Aug. 21-24—107th Annual Meeting, W. Va. State Medical Assn., White Sulphur Springs.

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1. Braverman, L. E., Ingbar, S. H., and Sterling, K.: Conversion of Thyroxine (T_4) to Triiodothyronine (T_3) in Athyreotic Human Subjects, J. Clin. Invest. *49*:855-64, 1970.
2. Surks, M. I., Schadlow, A. R., and Oppenheimer, J. H.: A New Radioimmunoassay for Plasma L-Triiodothyronine: Measurements in Thyroid Disease and in Patients Maintained on Hormonal Replacement. J. Clin. Invest. *51*:3104-13, 1972.

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WVU Medical Center –News–

• **Compiled from material furnished by Mrs. Mary Ellin Wylie, Director, Medical Center News and Information Services, Morgantown, W. Va.**

DR. John H. Vaughan, noted rheumatologist and immunologist of the Scripps Clinic and Research Foundation of La Jolla, California, will be the Alpha Omega Alpha Visiting Professor at the West Virginia University School of Medicine, January 14-18.

Doctor Vaughan, a native of Richmond, Virginia, graduated from Harvard College (*cum laude*) in 1942, and from Harvard Medical School in 1945. After completing his medical internship and residency at Peter Bent Brigham Hospital, he was a national research fellow in the laboratory of Dr. Elvin A. Kabat of Columbia-Presbyterian Medical Center, New York City; Assistant Professor of Medicine at the Medical College of Virginia, and Associate Professor and Professor of Medicine at the University of Rochester Medical School. In 1970, he became Chairman of the Clinical Divisions of Scripps Clinic and Research Foundation plus Adjunct Professor of Medicine at the University of California at San Diego.

Doctor Vaughan is a member of the American College of Physicians, American Association of Immunologists, American Academy of Allergy, American Federation for Clinical Research, American Rheumatism Association, American Society for Clinical Investigation, Association of American Physicians, Infectious Diseases Society, San Diego County Medical Society, Western Association of Physicians and the Western Society for Clinical Research.

His honors include AOA; Sigma Xi; President, American Academy of Allergy, 1966-67; and President, American Rheumatism Association, 1970-71.

He also has served as a member of the General Medicine and the Allergy and Immunology Study Section of NIH, Chairman of the Subspecialty Board of Allergy of the American Board of Internal Medicine and on the editorial boards of *Arthritis and Rheumatism, Journal of Allergy, Journal of Clinical Investigation, Journal of Immunology, Annals of Internal Medicine* and *Journal of Infectious Diseases.*

While at WVU, Doctor Vaughan will deliver the Annual AOA Lecture an January 14 at 4 P.M. He also will be spending time with the Departments of Medicine, Surgery, Pediatrics and the Basic Sciences.

All interested persons are cordially invited to attend any of the week's activities.

HELP HOTLINE Service

To enhance the quality of its service to patients, their families, visitors and staff, West Virginia University Hospital's administration has installed a HELP HOTLINE.

Purpose of the new program is to provide quick answers to questions and assistance in resolving University Hospital-related, non-medical problems such as admission arrangements, discharge policy, billings, insurance, housing or parking.

Posters, signs and "take home" cards in heavily used areas of the building inform the public of the administration's personal and special telephone service, located in and operated by staff members of the hospital's Social Service Department.

When someone telephones 293-HELP (4357), the message is recorded and relayed to the appropriate administrative officer for prompt action.

Since the Social Service Department at University Hospital has always provided assistance of this type to patients and their families, its staff members are informed and experienced and can solve many callers' problems immediately.

University Hospital's HELP HOTLINE functions 24 hours a day. From 8 A.M. to 5 P.M., it's based in Social Service. At all other times, messages are received, recorded and relayed from the HOTLINE extension in the hospital's admissions office.

Assistant Dean Named

John Arlen Thomas, Professor of Pharmacology, has been named Assistant Dean of the West Virginia University School of Medicine.

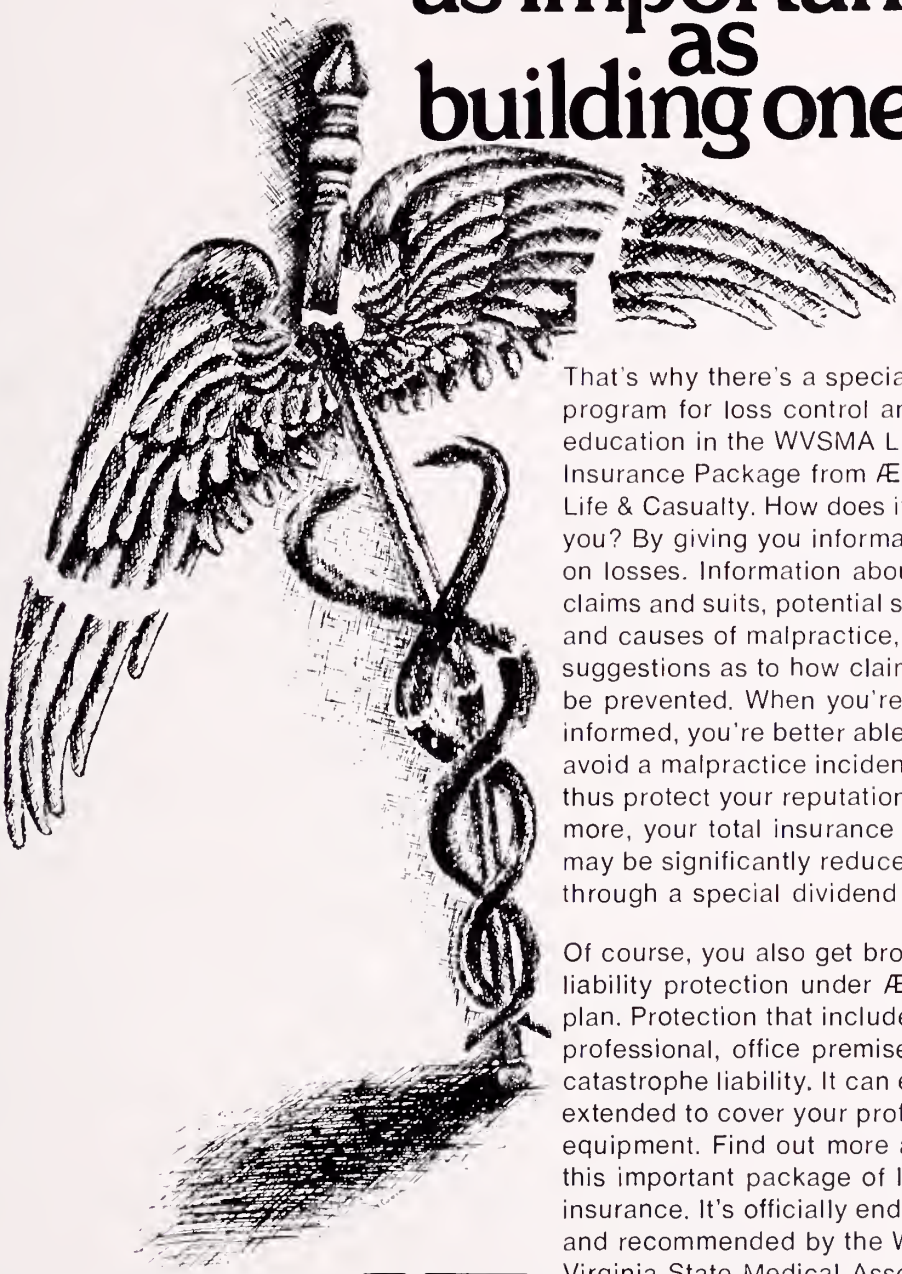
In his new position, Doctor Thomas' first major task will be to assist in Basic Sciences planning. His office will remain in the Department of Pharmacology.

In addition to his administrative duties, Doctor Thomas hopes to continue development of his research interests in endocrine pharmacology.

Doctor Thomas has published more than 100 scientific articles and is the co-author of a recently published book, "Synopsis of Endocrine Pharmacology." He also is the co-editor of the soon-to-be-released annual series, "Advances in Sex Hormone Research," which contains a collection of scientific papers from internationally recognized endocrinologists.

A graduate of the University of Wisconsin, Doctor Thomas received his master's and doctoral degrees from the State University of Iowa.

Protecting a reputation is as important as building one.



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The Month in Washington

• **From the Washington Office of the American Medical Association.**

Two more major national health insurance proposals have been thrown into the Congressional hopper, bringing the total to eight with at least two more waiting in the wings, including that of the Administration.

Chairman Harley O. Staggers (D-W.Va.) of the House Commerce Committee has introduced his own national health insurance proposal (NHI), saying hearings will be held on his bill in the coming year.

The second new NHI proposal came from Senate Republican leader Hugh Scott (R-Pa.) and Charles Percy (R-Ill.).

Staggers' National Comprehensive Health Benefits Act of 1973 would provide comprehensive health care benefits and complete protection against the costs of catastrophic illness to all. It would be financed by a combination of contributions from employers, the federal government and individuals, scaled to income. The federal funds are for health insurance and catastrophic illness benefits for the poor and near-poor.

The introduction came shortly before hearings on NHI by the Commerce Subcommittee on Public Health and Environment.

It is the first major NHI proposal to be referred to the Interstate and Foreign Commerce Committee rather than the Committee on Ways and Means, Staggers noted, adding that it is the first NHI proposal by a chairman of a major committee in the House.

Major features of the proposal, as described by Staggers:

—a strong role for state governments in the development and administration of the program;

—incentives for the creation and use of Health Maintenance Organizations;

—a six-year transitional period for orderly development;

—the use of existing private health insurance carriers for administration of the insurance provisions;

—and the fact that the program builds on, rather than federalizing, the existing health care system.

The bill provides that newly created State Health Commissions (SHC's) would be responsible for the actual administration of much of the program, including standard setting and quality control, assisting in the development of Health Maintenance Organizations (HMO's), and administration of some of the insurance provisions. Existing private health insurance carriers would be used to underwrite most of the legislation's insurance benefits. The development and use of HMO's would be encouraged through additional direct development assistance and through a 10 per cent federal subsidy of HMO premiums.

Within two years of enactment all aged, low income and unemployed individuals and families would be provided coverage for basic health services. Within four years of enactment, all individuals and families would be provided coverage for basic health services and the costs of catastrophic illness. Within seven years of enactment, all individuals and families would be provided coverage for comprehensive health care benefits and the costs of catastrophic illness.

Senator Scott said his two-part "Health Rights Act" would provide for in-patient protection for all persons suffering major illness, and would set up an out-patient health maintenance insurance plan. It would replace both the Medicare and Medicaid programs now in effect.

Under the Scott-Percy Health Rights Act, both the in-patient and out-patient plans would be administered by insurance carriers or other public or private agencies on a regional basis, under contract with the newly created Office of Health Care within the Department of Health, Education and Welfare.

The in-patient, "major illness" protection differs from traditional catastrophic plans by covering all costs above each family's health cost ceiling, which is determined by a formula taking into account both family income and family size. Money for the plan would be financed in part through the present health insurance portion of Social Security payroll taxes and in part through general revenues.

The out-patient plan would be financed in part through family premium payments which would be supplemented in whole or part with federal payments for low-income families. Employers could arrange to finance all or part of their employees' premiums.

The Act would also establish a two-year, Presidentially appointed "Health Delivery Committee" to study the current and long-range needs for medical personnel and facilities. It would make recommendations to the President and Congress.

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Obituaries

A. DAVID BELTON, M. D.

Dr. A. David Belton, who practiced in the Beckley area for 45 years before his retirement in 1972, died on November 12 in a Beckley hospital. He was 75.

A native of Palatka, Florida, Doctor Belton was a graduate of Lincoln University in Pennsylvania and received his M. D. degree in 1926 from Howard University College of Medicine in Washington, D. C. He interned at Freedmen's Hospital in Washington, D. C.

After a short period of practice in Mt. Hope, Doctor Belton began practice in Beckley in 1927. He had been the staff physician and instructor of nurses in neurology and psychiatry at Providence Hospital in Bluefield from 1928 through 1934, a member of the courtesy staff of the Beckley Hospital from 1934 to 1948, the physician for the West Virginia Home for the Aged and Infirm at McKendree (Fayette County), 1942-1956, clinician at the Raleigh County Pre-Natal Clinic, Department of Health; physician for the Raleigh County Jail, and examining physician for Beckley area Army officers seeking promotion in rank.

Doctor Belton served as Assistant Physician, Department of Internal Medicine at the Beckley Memorial Hospital, now Appalachian Regional Hospital, from 1956 to 1966. At the time of his retirement he was a member of the staff at the Southern West Virginia Clinic in Beckley.

He was a member of the Raleigh County Medical Society, the West Virginia State Medical Association, the National Medical Society, the American Medical Association and The Association of Former Interns and Residents of Freedmen's Hospital.

Surviving are the widow; a daughter, Sandra Belton of Chicago, and a brother, Wilbert Belton of Palatka.

* * * *

FRANK P. EVES, M.D.

Dr. Frank P. Eves of Charleston, who practiced medicine in Kanawha County for several years, died December 10 at the Veterans Administration Hospital in Beckley after a long illness. He was 84.

A World War I veteran, Doctor Eves was a native of Nashville, Tennessee, and received his medical degree from Vanderbilt University, in Nashville, in 1915.

He interned at Fordham University in New York City. Doctor Eves practiced in Brooklyn, New York, before coming to West Virginia, and was located at Ward, in Kanawha County, for a time.

He was a member of the Kanawha Medical Society, the West Virginia State Medical Association and the American Medical Association. Doctor Eves is survived by a brother, Robert L. Eves, of Nashville.

Dr. Thomas Langfitt To Speak At Stoneburner Event

Dr. Thomas W. Langfitt of Philadelphia will be among speakers for the 27th Annual Stoneburner Lecture Series to be offered February 7 and 8 at the Medical College of Virginia in Richmond.

The series, to be a postgraduate course in Clinical Advances in Medical and Surgical Neurology, will be sponsored by the Department of Continuing Education and the Division of Neurosurgery, School of Medicine, MCV, Virginia Commonwealth University.

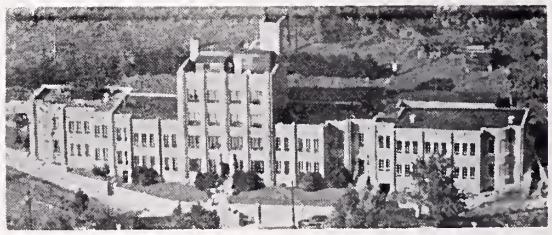
Doctor Langfitt, Charles H. Frazier Professor and Chairman of the Division of Neurosurgery at the University of Pennsylvania, is the son of the late Dr. Frank V. Langfitt and Mrs. Langfitt, of Clarksburg.

He will give two Stoneburner Lectures during the two-day series, with his first topic at 2 P.M. on Thursday, February 7, to be "The Interrelationship of Intracranial Pressure (Cerebral Blood Flow and Brain Metabolism in Experimental Brain Injury)."

At 2 P.M. on Friday, February 8, Doctor Langfitt will speak on "Clinical Advances in the Management of Patients with Severe Head Injury."

The continuing education program at the MCV School of Medicine is accredited by the American Medical Association, and application has been made to the American Academy of Family Physicians for 13½ hours of prescribed credit for the February program.

The $95 tuition fee for the course will include registration and lunch on each of the two days.



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County Societies

CABELL

New officers for 1974 were elected at the meeting of the Cabell County Medical Society on November 8 at the Holiday Inn in Huntington. The recommendations of the Nominating Committee were unanimously accepted. The new officers are Drs. Edwin J. Humphrey, III, President; Gerald E. Vanston, President-Elect; Robert L. Dunworth, Vice-President; Charles H. McKown, Jr., Secretary; and William J. Echols, Treasurer.

The guest speaker was the Huntington City Manager, who discussed the Civic Arena Development in Huntington.

The Society voted to support plans for two new emergency communication systems between the two major hospitals in Huntington.

The Committee on Physician Recruitment announced that a brochure promoting the advantages of the Huntington area for the practice of medicine was in the process of being produced.—Charles H. McKown, Jr., M. D., Secretary.

* * * *

MERCER

The Honorable Edgar Heiskell, III, West Virginia's Secretary of State, gave an interesting

(Continued on page xvi)

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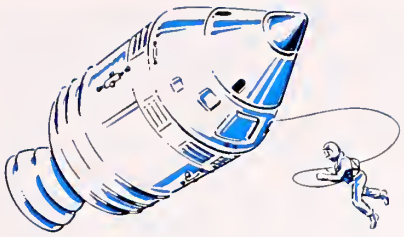

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talk on election laws and possible means of strengthening them at the November 19 meeting of the Mercer County Medical Society at the University Club in Bluefield.

New Society officers elected for 1974 include Drs. Hawey Wells, President; James Thomas, Vice President; and John J. Mahood, re-elected Secretary-Treasurer—John J. Mahood, M.D., Secretary.

* * * *

MONONGALIA

Drs. Allen Bowyer, Robert Marshall and Thomas Tarnay offered an informative program entitled "Current Trends in Management of Coronary Disease" at the November 6 meeting of the Monongalia County Medical Society at the International Club in Morgantown.

Accepted as new members were Dr. William Lee Mossburg, a resident in surgery at the West Virginia University Medical Center; and Dr. John Wolf, a Morgantown allergist.

The Society voted to again sponsor a program to encourage medical students, interns and residents to write clinical or research papers for reading before the membership; and heard a further progress report on development of the Family Practice Program at WVU.—H. Summers Harrison, M.D., Secretary.

TYGART'S VALLEY

Dr. Donald McDowell, a medical missionary to Paraguay, was the guest speaker for the meeting of the Tygart's Valley Medical Society on November 15 at Iaquinta's Restaurant in Galloway (Barbour County).

Doctor McDowell showed pictures of the mission and hospital at which he worked. He also illustrated his talk with pictures of surgery and the various diseases he encountered while practicing in that part of the world.

The following new officers for 1974 were elected: Drs. Robert R. Rector of Elkins, President; Ernest G. Guy, Philippi, First Vice President; Gene W. Harlow, Grafton, Second Vice President; A. Kyle Bush, Philippi, Secretary; and Vernon E. Duckwall, Elkins, Treasurer.

Dr. K. P. S. Menon was elected to membership in the Society.—A. Kyle Bush, M. D., Secretary.

AMA Opposes Restrictions On FDA Authority

The American Medical Association has asked the Congress to reject proposed legislation that would restrict the Food and Drug Administration's authority over food supplements.

In testimony before the House Commerce Subcommittee on Health and Environment, C. E. Butterworth, Jr., M. D., Chairman of the AMA's Council on Foods and Nutrition, said the FDA's actions "are based upon sound scientific evidence and are clearly in the public interest."

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Jomes A. Gordner, M. D.

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Clifford A. Stevenson, M. D.
S. A. Zahir, M. D.
Morio C. Ramas, M. D.

Obstetrics-Gynecology
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Worren D. Elliott, M. D.
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Woman's Auxiliary

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Recording Secretary: Mrs. Claude S. Lawson, Jr., Fairmont
Corresponding Secretary: Mrs. W. Paul Elkin, Charleston
Parliamentarian: Mrs. Robert G. Janes, Fairmont

HARRISON

Mrs. Ann Casey, Consumer Service Specialist for Consolidated Gas Company, presented an interesting program on "Holiday Garnishes" at a December 4 meeting of the Woman's Auxiliary to the Harrison County Medical Society in Clarksburg. The Auxiliary held a cookie sale prior to the meeting for the benefit of the American Medical Association-Education and Research Foundation.—Mrs. Janice E. Fiester, Press and Publicity.

* * * *

KANAWHA

The Woman's Auxiliary to the Kanawha Medical Society heard an interesting review of Appalachian dialects by Mrs. Wylene Dial at its November meeting at the home of Dr. and Mrs. Ramon Portales in Charleston. Mrs. Dial, a Lincoln County resident, is an extension specialist for the aging for West Virginia University.—Mrs. Spencer L. Bivens, Jr., Press and Publicity.

* * * *

McDOWELL

The Woman's Auxiliary to the McDowell County Medical Society honored Mrs. J. Dennis Kugel and Mrs. James H. Walker, both of Charleston and President and Vice President, respectively, of the Woman's Auxiliary to the West Virginia State Medical Association, at a November 14 luncheon.

The luncheon was held at the home of Dr. and Mrs. Robert Hansen in Welch. Mrs. Kugel outlined the State Auxiliary's activities, and Mrs. Walker spoke of advantages offered by membership in the woman's organization.—Mrs. Allan A. Carr, Press and Publicity Chairman.

* * * *

RALEIGH

Dr. Eugene Warvariv, President Elect of the Raleigh County Medical Society, gave an interesting talk on the new federal Professional Standards Review Organization (PSRO) statute at a November 19 meeting of the Woman's Auxiliary to the Raleigh society. The meeting was held at the home of Dr. and Mrs. Charles W. Nelson, Jr., in Beckley—Mrs. John A. McKenzie, Press and Publicity Chairman.

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D. C. Trapp, M. D.

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K. W. Waterson, M. D.
Sheldon Widlan, M. D.

Internal Medicine:
Charles H. Hiles, M. D.
Albert M. Valentine, M. D.
C. A. Vasquez, M. D.

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Stephen D. Ward, M. D.
Michael McNeer, M. D.
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Technologists:
Electrocardiography:
Betty Maguire, R. N.
Brenda Muklewicz, R. N.
Electroencephalography:
Joann Green, R. N.
Juanita Stone, R. N.
Roentgenology:
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Book Reviews

THE PERSECUTED DRUG: THE STORY OF DMSO—By Pat McGrady, Sr., retired Science Editor of the American Cancer Society. New York. Doubleday & Company, Inc., Garden City, N. Y. 1st Edition. 1973. Pg. 372. Price: $7.95.

Science writer Pat McGrady, Sr., relates the history of the problems associated with getting federal recognition of dimethyl sulfoxide (DMSO) as a drug. This liquid organic chemical has many uses as a clinical agent. Because its appearance as a drug or drug vehicle came shortly after the thalidomide disaster, a distorted federal scrutiny blocked its commercial appearance. This happened even after DMSO had been shown to have little toxicity in both animal and human studies. Stanley W. Jacob, M. D., bore the brunt of the attack by F.D.A. agents and the recent recognition of DMSO as a new therapeutic principle is a tribute to his sincerity and determination.

This book should be of solid interest to the medical community because it reveals many of the medical possibilities of DMSO. It is written in a readable style although it consists mainly of case histories which border on the unbelievable.

As with any work of this type, the negative side of the DMSO story is not clearly revealed. Because DMSO acting as a drug vehicle penetrates membranes so easily it can convert a normally non toxic substance into a lethal one. However, it can also convert a drug that cannot penetrate membranes well into one that is a good membrane penetrator. This has obvious clinical potential which few if any agents share.

The chemistry of the drug is improperly explained with the correct bonds omitted and charges on atoms reversed. One might surmise that the book was not carefully researched from this point of view. One would hope, however, that the book would help reverse the federal stand on this agent.—Knox Van Dyke, Ph. D.

Purdue Researchers Transplant Embryonic Brain Cells

Purdue University researchers have successfully transplanted embryonic brain cells in young animals, a step that adds to an understanding of brain injury and how it may be corrected.

The research team, headed by Dr. Gopal D. Das of the Department of Biological Sciences, found that transplanted immature brain cells became functional and were not rejected by the host cells. Their results demonstrate that nerve cell transplantation is possible if the donor cells are immature and the host brains are still developing.

Dr. Das' group also found that during embryonic development of the brain, different nerve cells evolve at specified times and from specified regions of the brain. This data may be very important in aiding clinicians to better understand and correct damage or abnormalities in an embryo's developing brain.

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WANTED—Internist urgently needed in a growing northeastern West Virginia community; drawing area is approximately 23,000; modern hospital with excellent facilities; office space available; guaranteed annual income; centrally located for vast recreational facilities. Write RLH, The West Virginia Medical Journal, P. O. Box 1031, Charleston, W. Va. 25324.

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WANTED—A physician to serve the area of Pennsboro in Ritchie County. A building to accommodate two physicians and one dentist has been completed. Citizens of Pennsboro guarantee that the physician will receive cordial reception and the area offers a wonderful opportunity for a young, ambitious physician. If interested, contact Mrs. J. Carl Rinehart, Pennsboro, W. Va.

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Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal m be associated with temporary increase in frequency and/or seve of seizures. Advise against simul taneous ingestion of alcohol and other CNS depressants. Withdra symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt disco tinuance (convulsions, tremor, al dominal and muscle cramps, vomi and sweating). Keep addiction-pr individuals under careful survei lance because of their predisposi to habituation and dependence. I pregnancy, lactation or women o childbearing age, weigh potential benefit against possible hazard.

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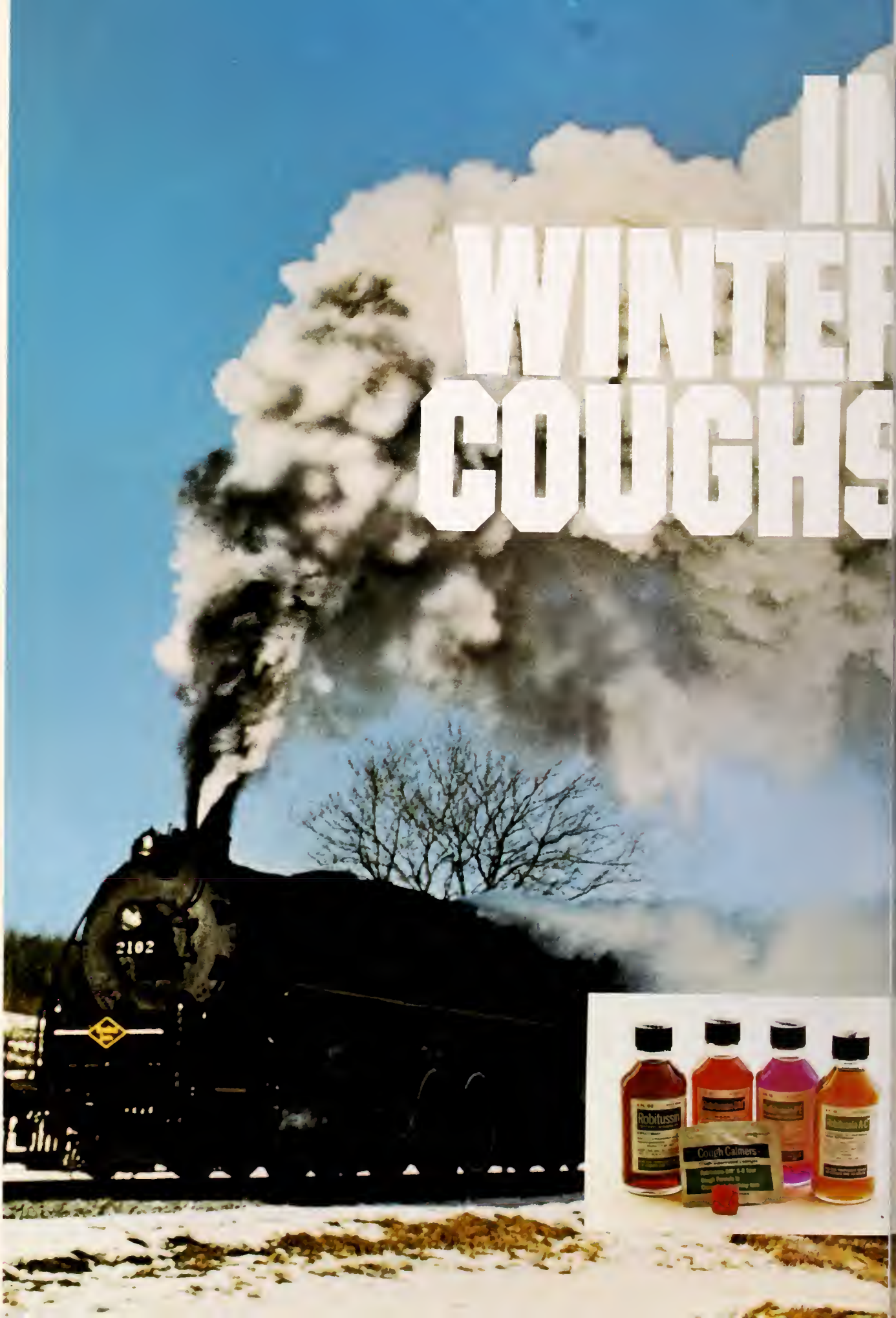
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Joint Statement on Antisubstitution Laws and Regulations

The purpose of this statement is to affirm the support of the participating organizations for the laws, regulations and professional traditions which prohibit the unauthorized substitution of drug products.

Traditionally, physicians, dentists and pharmacists have worked cooperatively to serve the best interests of patients. Productive cooperation has been achieved through mutual respect as well as a common concern for the ideals of public service. This mutual respect has been reflected, in part, by joint support over the years for the adoption and enforcement of laws and regulations specifically prohibiting unauthorized substitution and encouraging joint discussion and selection of the source of supply of drug products. The basic principles of medical, dental and pharmacy practice are thus utilized and preserved in the interest of patient welfare.

The antisubstitution laws have not obstructed enhancement of the professional status of pharmacy any more than they have in and of themselves guaranteed absolute protection from unsafe drugs, or freed physicians, dentists and pharmacists from their responsibilities to patients. As a practical matter, however, such laws and regulations encourage interprofessional communications regarding drug product selection and assure each profession the opportunity to exercise fully its expertise in drug usage, to the advantage of patients.

Physicians and dentists should be urged to increase the frequency and regularity of their contacts with pharmacists in selection of quality drug products, recognizing that economies to patients can be improved through such communication, taking into account the patients' needs. The pharmacist's knowledge of the chemical characteristics of drugs, their mode of action, toxic properties and other characteristics that assist in making drug selection decisions should be utilized to the fullest extent practicable by physicians and dentists in serving their patients.

Since drug product selection entails knowledge derived from clinical experience, the physician's and dentist's roles in product selection remain primary and do not permit delegation of decisions requiring medical and dental judgments. A broader role in therapy will evolve for pharmacists as improved understanding and cooperation among the professions continue to grow.

There has been no evidence that there are convincing reasons to modify or repeal existing laws and regulations prohibiting the unauthorized substitution of another drug product for the one specified by a prescriber. It is our belief that such laws and regulations merit the joint support of the medical, dental and pharmaceutical professions and the pharmaceutical industry.

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We hope to reach women in the target group not only with the message about the *vital* Pap test, but also with the urgency of including it in the *regular* health checkup. The mortality rate from uterine cancer could thus be dramatically curtailed.

Clearly action is called for. Coordinated action—involving the doctor, the patient, the American Cancer Society—a partnership for life.

a partnership for life

American Cancer Society

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PRESCRIBING INFORMATION

Antiminth (pyrantel pamoate) Oral Suspension

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13μg/ml.) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 cc.)

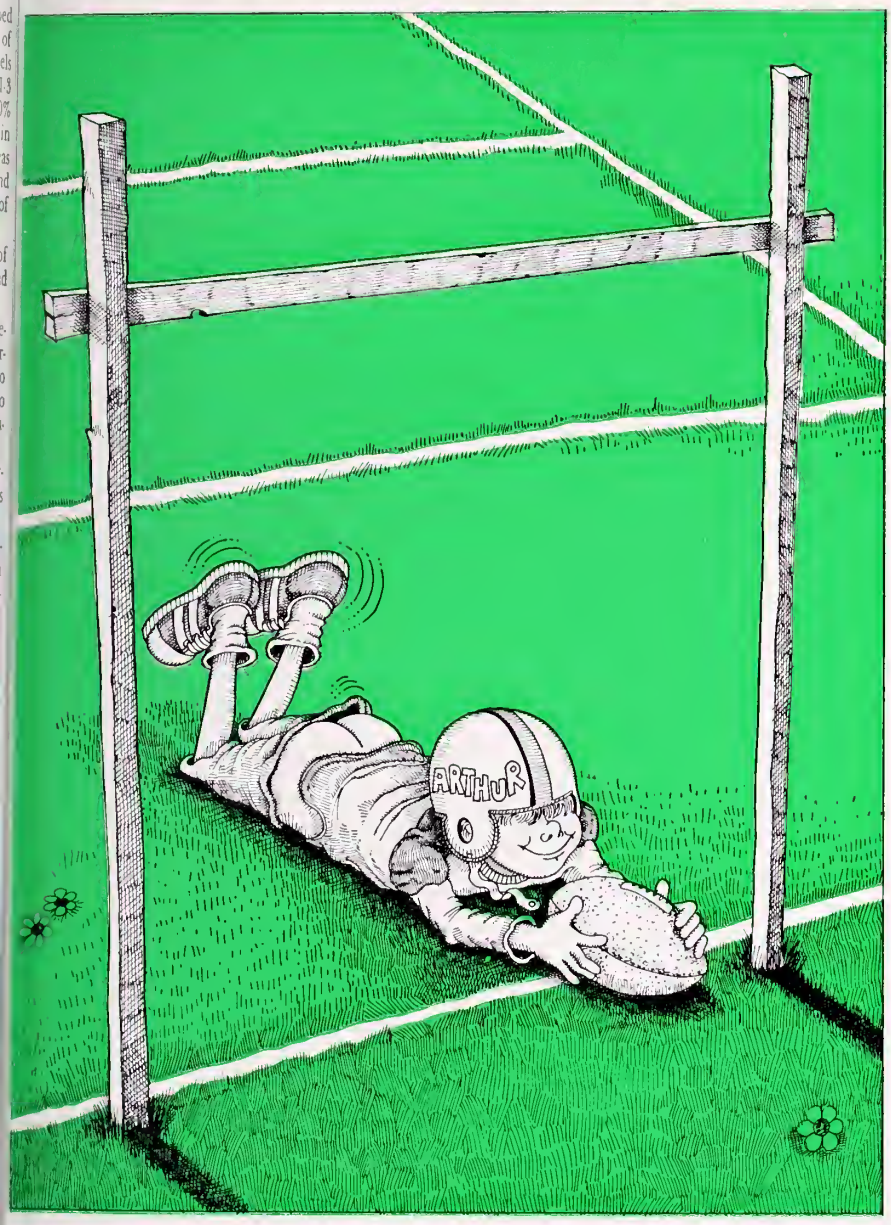
Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day; and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices. Because of limited data on repeated doses, no recommendations can be made.

How Supplied. Antiminth is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg. pyrantel base per ml., supplied in 60 cc. bottles.

ROERIG Pfizer

A division of Pfizer Pharmaceuticals
New York, New York 10017

WORMS BLITZED



A single dose of Antiminth (1 cc. per 10 lbs. of body weight, 1 tsp./50 lbs.—maximum dose, 4 tsp=20 cc.) offers highly effective control of *both* pinworms and roundworms.

Antiminth has been shown to be extremely well tolerated by children and adults alike in clinical studies.* Pleasantly caramel-flavored, it is non-staining to teeth and oral mucosa on ingestion... doesn't stain stools, linen or clothing.

One prescription can economically treat the entire family.

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Pinworms, roundworms controlled with a single, non-staining dose of

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(pyrantel pamoate)

equivalent to 50 mg. pyrantel/ml.

ORAL SUSPENSION

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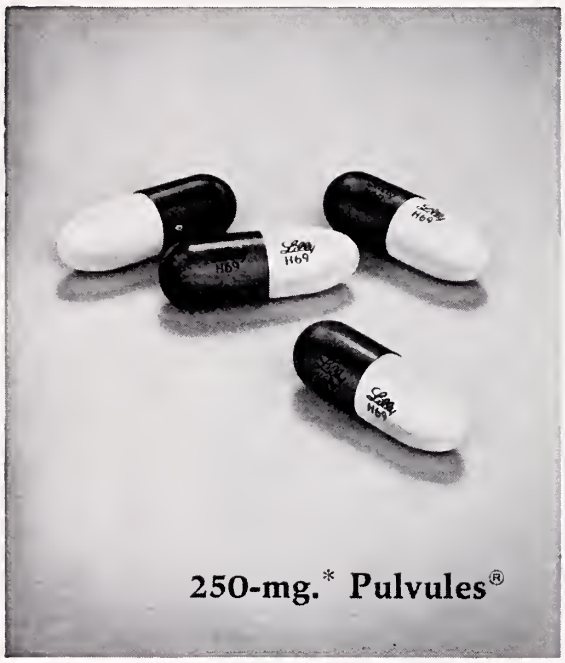

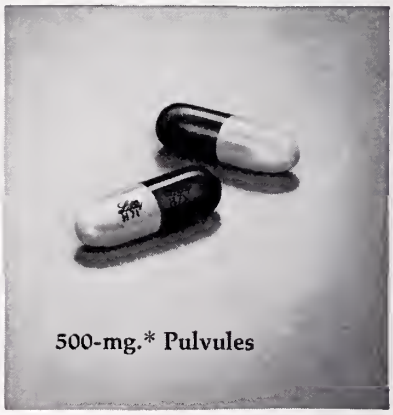

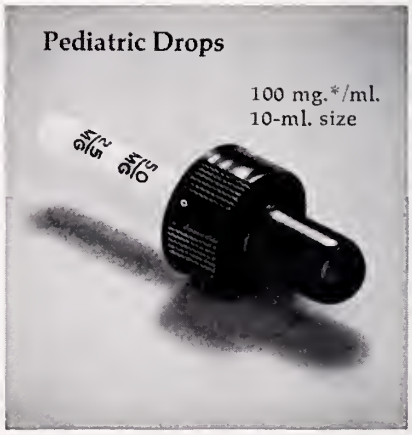

*Equivalent to cephalexin.

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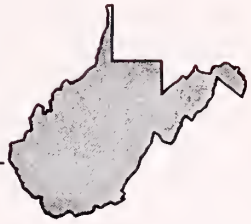

Vol. 70, No. 2 February, 1974

By-Pass Procedure For Palliation In Obstructive Jaundice*

Catalino B. Mendoza, Jr., M.D., and George W. Easley, M.D.

Carcinoma of the pancreas is steadily increasing in frequency in the United States.[11] In spite of advances in diagnostic and clinical skill, the survival rate remains low.[12, 13] When obstructive jaundice is the presenting symptom and the tumor is nonresectable, palliation can be obtained by biliary enteric anastomosis.

A retrospective study of 141 cases of tumor of the pancreas in the Veterans Administration Hospital at Clarksburg, West Virginia, for a 20-year period (1951-1972) was analyzed. Thirty-two of these patients (average age 66 years) had inoperable carcinoma with severe obstructive jaundice, and a biliary enteric shunt for palliation was carried out. Cholecystojejunostomy was performed in 20 cases. With these procedures, two types of anastomosis were utilized, cholecystojejunostomy with Roux-en-Y (Figure 1) in nine cases, and cholecystojejunostomy loop (Figure 2) in 11 cases. The length of the jejunal loop varied from 15 to 25 inches from the ligament of Treitz to the anastomosis of the loop at the fundus of the gallbladder. The average length was approximately 18 inches. A double-layer type of closure was performed, using 000 chromic catgut for the inner layer and 000 black silk interrupted sutures for the outer layer.

The other twelve patients had other types of biliary decompression (Table 1).

Table 1

Other Types of Biliary Decompression

Cholecystoduodenostomy	5 Patients
Choledochojejunostomy	2 Patients
Choledochoduodenostomy	2 Patients
Cholecystogastrostomy	3 Patients

*Presented at a meeting of the West Virginia Chapter, American College of Surgeons, at Morgantown, West Virginia, October 28, 1972.

The Authors

- **Catalino B. Mendoza, Jr., M.D., Assistant Professor of Surgery, West Virginia University School of Medicine, Morgantown, and Consultant in Surgery, Veterans Administration Hospital, Clarksburg; and George W. Easley, M.D., Associate Professor of Surgery at WVU and Chief of Staff, VA Hospital, Clarksburg.**

Results

There was one failure among the patients who had a cholecystojejunostomy loop. Approximately two weeks following surgery, one 67-year-old male developed progressive jaundice and clay-colored stool. During surgery a T-tube had been inserted and an operative cholangiogram revealed a dilated common duct about one and one-half cm. in diameter. The cystic duct was

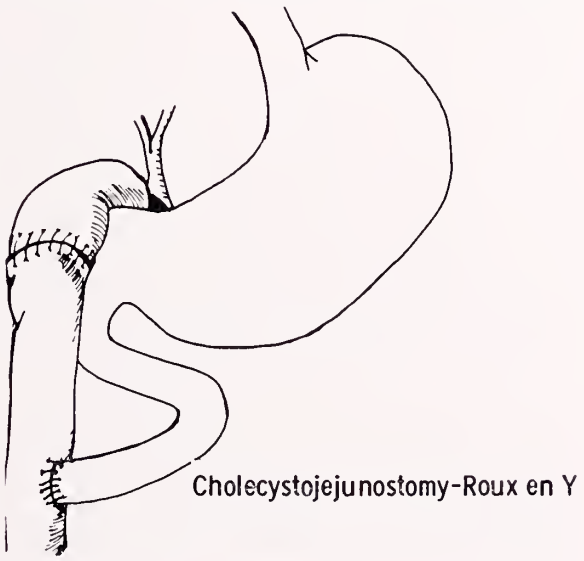

Figure 1. Diagram of procedure performed in nine cases.

normal in size. The distal common duct was completely obstructed by the tumor in the head of the pancreas. Another T-tube cholangiogram carried out following surgery failed to demonstrate the gallbladder. The patient was again operated on and a choledochojejunostomy was performed. Postoperatively his course was uneventful and he was discharged. Four months later he developed gastric outlet obstruction and a gastrojejunostomy was performed for its relief. A month following the operation the patient died and no autopsy was obtained.

Of the remaining 14 patients without gastrojejunostomy, one developed gastric outlet obstruction and a gastrojejunostomy was performed. The patient lived less than six months following this procedure.

Serum bilirubin studies were done on all patients preoperatively and postoperatively. The average drop in bilirubin levels one month after surgery was 11.2 mg. per cent (total).

Table 2 demonstrates the mortality during hospitalization. Length of survival is depicted in Table 3. Sixteen patients died in the hospital of which number permission for autopsy was obtained in three cases. Four patients died at home. The cause of death in all cases was attributed to the malignant disease.

Table 2

Mortality Within 30 Days of Hospitalization

Cause of Death	Number Patients
Renal Failure	2
Respiratory Failure	1

Table 3

Survival Time

Interval from Surgey Until Death:	
Less Than 6 Months	15 Patients
6-12 Months	3 Patients
13 Months (Maximal Survival)	2 Patients

Discussion

The surgical mortality rate from cholecystojejunostomy varies from 15 per cent[1] to 23.7 per cent.[2] The patients in this study were males in the older age group, and the over-all mortality rate was 15 per cent. The longest survival period reported following cholecystojejunostomy is 13 months,[4] with the average being six months.[3] In our series of cases, the average survival rate was four months; only two patients lived more than one year.

We have noted disappearance of jaundice beginning in four to eight weeks, as previously reported by Jordan.[4] Bufkin,[1] et al, reported an average decrease of 11.0 mg. per hundred ml. bilirubin in 78 per cent of 157 cases. We have

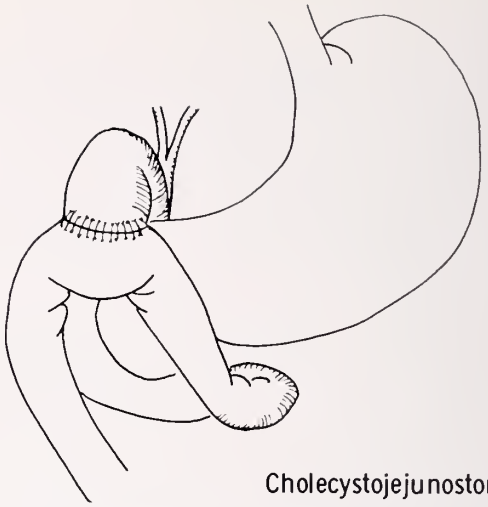

Figure 2. Diagram of procedure performed in 11 cases.

found in our cases a drop of 11.2 mg. per hundred ml. in four weeks. In cases in which there was obstructive jaundice and in which the gallbladder had been previously removed, we elected to do a choledochojejunostomy or choledochoduodenostomy, provided the tumor did not obstruct the duodenum, as suggested by others.[8, 9, 10]

The mortality rate following choledochojejunostomy is high, varying from 20 per cent[3] to 37 per cent.[1] In our experience, which is limited, the mortality rate has been 50 per cent.

The incidence of gastric outlet obstruction following biliary by-pass for inoperable carcinoma of the head of the pancreas is high. Some investigators have reported a 50 per cent occurrence.[7] In our series of cases, the rate has been about 28 per cent. With anticipation of obstruction in the cases of those patients with large tumors of the head of the pancreas, we elect to do a gastrojejunostomy. Other investigators have agreed with this practice.[5, 6]

In conclusion, in the cases of patients with obstructive jaundice with a nonresectable tumor, our procedure of choice is a cholecystojejunostomy loop if the cystic duct is patent. If the tumor is large, with anticipation of gastric outlet obstruction, we elect to do a gastrojejunostomy. In the cases of patients who previously have undergone cholecystectomy, or in the absence of the gallbladder, we have utilized a choledochojejunostomy. In our experience, all patients had palliation by a decrease in jaundice and had added comfort during their last few weeks of life.

A list of references may be obtained by writing The Journal.

Behavior Modification With The Severely Mentally Retarded

Jaime E. Lazaro, M.D., and William J. Wyatt, M.S.

The advent of the Geographic Unit System at Huntington State Hospital ended the presence of a "back ward" housing facility for all of the resident severely mentally retarded patients. These patients, generally untidy and lacking in the most basic self-care skills, were relocated throughout the hospital. Several such patients reside on each ward of the hospital and it is with one such group of eight patients on Ward Six of Huntington State Hospital that this study deals.

Several experimenters have successfully applied operant conditioning techniques in training severely and profoundly mentally retarded individuals in self-care skill including: Bensberg (1965); Grabowski and Thompson (1972); Bensberg, Colwell, and Cassell (1965); Minge and Ball (1967); Hundziak, Maurer, and Watson (1965); Wisen and Watson (1967); Henriksen and Doughty (1967); Hamilton, Stephens, and Allen (1967).

Because severely retarded patients tend to be long-term or life-time admissions to the hospital, a rather intensive self-care training program would seem to be of great value. In addition to helping the patient, such a program may result in the need for less personnel. As Ellis (1963) has said, for example, it would seem rather costly to work so intensively for six months or a year in training a severely mentally retarded individual. But when it is considered that the patient may have an additional 50 years of life expectancy, then cost seems minimal.

The Authors

- **Jaime E. Lazaro, M.D., Formerly Superintendent and Clinical Director, Huntington State Hospital, and now in the private practice of medicine in Clarksburg; and William J. Wyatt, M.S., Staff Psychologist, Huntington State Hospital.**

Method

Subjects.—Eight severely mentally retarded, ambulatory, male patients were selected as being most in need of self-care training among those patients housed on Ward Six. The eight patients ranged in age from 31 to 65 years with the average age being 45.5 years at the beginning of training on October 16, 1972. The patients represented long-term admissions. At the start of the training program, the patients had been hospitalized an average of 23.6 years, with the length of stay ranging from 12 to 55 years.

Six of the patients were food stealers during mealtime, although exhibiting varying degrees of aggressiveness in doing so, with two patients eating all meals in a seclusion room, so aggressive were they in their attempts to grab food from trays belonging to other patients. Only two patients were never observed to steal food. Of the eight patients, six seldom wore clothing, while two others wore clothing most of the time but not always. Five patients were completely toilet trained while two were completely incontinent and one was a bed wetter, although otherwise toilet trained. None of the eight patients performed any useful work on the ward, although six were able to respond appropriately to the very simplest of commands, such as "come" or "sit."

Procedure.—One Psychiatric Aide position was allocated on the day shift of Ward Six to help carry out the program. The individual was selected on the basis of recommendations, knowledge of operant techniques, and willingness to work in such a program. All training was carried out during the day shift with minimal help from evening or night shift personnel.

Baseline data on the patients' dress and food stealing habits were collected for one week prior to the beginning of training. The baseline data on patients' toilet habits, ward work history and aggressive tendencies was obtained through observation during the baseline week as well as a review of each patients' case history and conversation with ward personnel.

Reinforcers consisted of candy, sugar coated breakfast cereal, carbonated beverages, coffee, tea, Kool-Aid and cigarettes, as well as social reinforcement which consisted of praise. Social reinforcement was paired with edible reinforcement.

An attempt was made to reduce food stealing at mealtime. Mild aversive techniques were employed. With the Psychiatric Aide standing behind a patient any attempt at reaching for food on a neighbor's tray resulted in the offender's hands being held fast against the table top for approximately 60 seconds. Two patients were extremely aggressive, however, in their attempts to steal certain foods such as coffee, tea and Kool-Aid, and had previously been placed in seclusion rooms to eat all meals. Once training began, these two patients were allowed to begin each meal seated with the other patients but when stealing occurred they were removed with their food tray to a seclusion room for the remainder of their meal. When they remained seated at the table without stealing, more of the desired foods were given to the patient by the Psychiatric Aide.

During the week of baseline observations, two basic reasons for patients' disdain for wearing clothing were encountered: (1) an inability to button or zip clothing due to inadequate dexterity and lack of training, and (2) a simple dislike for wearing clothing. For the former type of patient, special clothing was obtained consisting of T-shirts and trousers with an elastic waistband and no buttons or zippers. The latter type of patient was reinforced several times daily with praise and treats for wearing clothing.

Toilet training was attempted with the patient being placed on the toilet and reinforced at first for sitting on the toilet, later only when he excreted into the toilet. Several such sessions were conducted each day at regular intervals with some sessions occurring when the patient was about to urinate or defecate on the floor.

Some of the patients were trained by shaping techniques to take more responsibility for general cleanliness of the ward. With a goal of training the patient to clean off tables and chairs after mealtime, the Aide placed a damp cloth in the patient's hand and bodily pushed the patient's hand back and forth in a "cleaning" motion over a small portion of the table surface. Each time this was done, a small reinforcement was administered. A similar technique was used in teaching the patient to mop the floor with the Aide first administering a small reinforcement when the patient, with the help from the Aide, mopped a small area of the floor. Larger rewards were administered when the patient mopped larger areas of the floor. Similar techniques were used in training patients to perform various other Ward jobs.

Results

After six months of training the patients were evaluated for a one-week period. Results of this evaluation were then compared with the original baseline observations. Group data on the patients' food stealing and clothes wearing behavior are presented below as most patients were involved in these phases of training. Toileting and work training were carried out with two or three designated patients and the results of these areas of training follow the group results for dress and food stealing behavior.

Food Stealing.—Instances of attempted food stealing at the lunch meal were reduced 78 per cent following six months of operant training. Attempts at stealing food fell from 35 attempts during the baseline week to only eight attempts during the evaluation week six months later. Even more meaningful is the fact that included in the evaluation week results are observations of the two extremely aggressive patients, whose behavior was *not* included in the baseline data because they had eaten in seclusion during the baseline week, although during the evaluation week they were able to eat with the rest of the group, so improved was their behavior.

A t-test was performed and the reduction in food stealing was found to be significant at the .01 level of confidence. Figure 1 represents the daily breakdown of food stealing both for the baseline week and the evaluation week.

Dress.—Instances of patients being unclad were reduced 92 per cent following six months of operant training and the introduction of more suitable clothing. The results are presented in

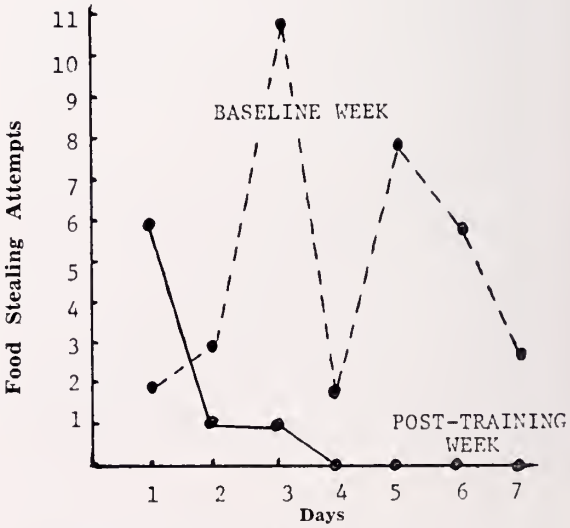

Figure 1. Attempts at stealing food before and after training.

Figure 2. A t-test was performed and the increase in wearing clothes was found to be significant at the .01 level of confidence.

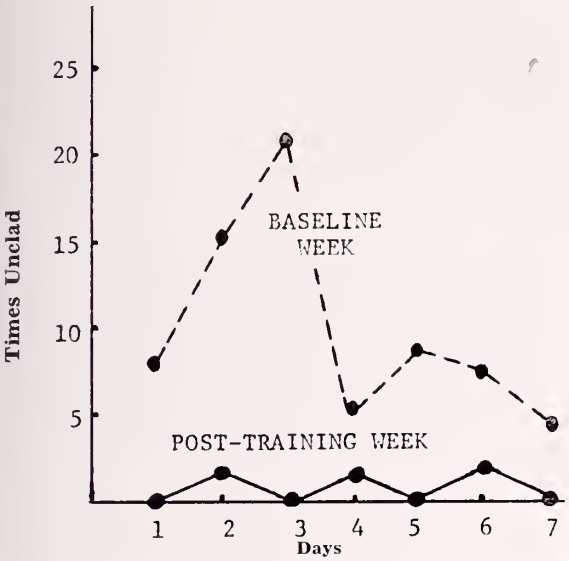

Figure 2. Instances of being unclad before and after training.

Toileting.—Toilet training for the two totally incontinent patients was begun at the beginning of the sixth month so that the results presented are based on only one month of training.

Patient number one was placed on the toilet several times per day and was reinforced approximately once every sixty seconds while he remained on the toilet. He received reinforcement at the rate of one per second whenever urination or defecation occurred. At the end of a month of training the patient was walking to the toilet and urinating on his own. Although he had defecated in the toilet of his own initiative on occasion, he still continued to defecate on the dorm floor most of the time. It is hoped that continued training will result in total toilet training for this 44-year-old patient who has resided in the hospital for 22 years.

Patient number two was quickly toilet trained by showering him with cool water each time he soiled himself. The patient had previously been observed to enter a shower stall fully clothed while other patients were being showered, indicating a liking for the usual warm showers he regularly received each time an Aide found that he had soiled himself. It then became clear that he had been regularly reinforced with warm showers each time he soiled himself, thus learning to soil himself as much as possible. With only occasional regression to soiling himself, this patient has, since the second day of training, used the toilet acceptably.

Work on the Ward.—Several patients were trained to perform useful work on the ward. With an Aide issuing paper towels and administering candy rewards one of the most aggressive and hyperactive patients was quickly trained to clean feces from the floor, deposit them in the toilet and flush the toilet. Such training was extremely helpful in keeping the ward clean, in preventing other patients from eating or playing in feces found on the floor, and in relieving Aides of some of the "babysitter" duties which had previously prevented their having time to engage in other forms of patient treatment.

A second patient was trained to gather all the dirty laundry each day and carry it to the ward laundry chute. A cigarette was the reinforcing agent in this case. This patient also learned to mop small areas of the dorm floor although progress was quite slow in this area. After several weeks of training, however, the patient began to initiate work instead of being prodded by the Aide.

A third patient turned out to be a "prized pupil." With good initiative behavior, this patient was first trained to clean a small area of the dining table with a damp cloth. He quickly learned that he could receive a larger reward by cleaning a larger area of the table and soon was cleaning the entire table top and all the chairs, and stacking the chairs on the table in order to receive two cups of coffee. He was then given training in mopping and in a few weeks learned to mop the entire dorm floor although it was necessary for an Aide to be present at all times or the jobs were not completed. The Aide then began to leave the dorm for short "breaks" in hopes that the patient could be trained to keep working even though no supervision was present. At the end of six months of training, the patient was mopping the entire floor, in addition to cleaning and stacking tables and chairs. All this work was being done quite well and was being performed twice per day with no supervision.

Discussion

Several important factors should be considered in formulating a program such as that described here. Primary among them is the need for a change in some staff members' attitudes toward training severely mentally retarded patients. While the one full-time Psychiatric Aide performed very well, some staff members appeared to have a pre-existing "custodial care" attitude and may have harbored negative feelings toward the possibilities of success for training the severely retarded. Thus, there is a need for some education of any staff member who may be even

remotely involved in the training program as to the possibilities for success or failure, methods used, and precedent programs. It should be pointed out to all personnel who may potentially be involved, even in a small way, that the learning process for the severely retarded is slow and painstaking and will not work in all cases, but that some patients will benefit.

The importance of constancy of environment also should be mentioned. As Henriksen and Doughty (1967) and Ellis (1963) have pointed out, the same Aide or Aides should be used every day, with the exception of days off, in order to maximize the chance of success of such a program. Although the inhibiting effects of using various Aides is not known, it should be reported that in the training described in this paper, some Aides filled in as well as could be expected when the assigned Aide was "pulled" to work on other wards. On various occasions, the patients did not receive scheduled training due to last minute reassignment of the Aide to other wards, usually due to illness of staff on other wards. We can only assume that the results of training would have been even better had training not often been interrupted for 24 or 48 hours at a time.

The difficulty in determining what is reinforcing for each patient should be mentioned. While some patients responded to typical reinforcers such as candy, pop and Kool-Aid, others appeared indifferent toward these items. Thus, a "wait and see" attitude while attempting various forms of reinforcement probably should be employed.

Summary

Eight severely mentally retarded males were given six months' training in self-care and other skills. Operant training techniques were used. Improvement was noted in the training areas including dress, food stealing, working on the ward and toileting. Other patients may benefit from an expanded program of training by employing the same techniques.

A list of references may be obtained by writing The Journal.

To Physicians in Training

To all physicians in training and especially West Virginia residents. West Virginia is in need of physicians in all categories for rural and urban practice. Any physician desiring information concerning openings in the State can communicate with *The Journal*. *The Journal* will publish free for 6 issues pertinent information concerning any qualified physician who is seeking a location in West Virginia. Single copies of *The Journal* listing practice opportunities will be mailed to physicians upon request.

A roster containing a list of officers of county societies and specialty sections of the West Virginia State Medical Association is available upon request to the headquarters offices. Also, information pertaining to West Virginia licensing laws will be mailed to interested physicians. Interested parties may then write the officers of component societies or sections for further information.

Any other information about West Virginia will be secured from outside sources, if possible, and sent upon request. All letters to *The Journal* will receive individual immediate attention.

Infarcted Omentum Simulating Acute Appendicitis

(Report Of Three Cases)

Gabriel Al-Hajj, M.D.; Raymond C. Bonnabeau, Jr., M.D.; William C. Dressler, M.D., and Mansour Jadalizadeh, M.D.

INFARCTED omentum simulating acute appendicitis has been recognized as an entity since 1899, when Eitel published the first report on the subject (A Rare Omental Tumor, Med. Rec. 55: 715-16, 1899). Many cases have since been reported. While some are considered to be idiopathic, others have been related to trauma, neoplasia, adhesions, inflammation, or to hematologic or vascular disorders.

This paper reviews three additional cases (Table 1) of infarcted omentum which simulated acute appendicitis upon initial presentation.

Case Reports

*Case 1.**—An eight-year-old white female developed abdominal pain approximately one day prior to hospitalization. There had been no nausea, vomiting or diarrhea and there was no prior history of abdominal trauma.

Initial physical examination revealed a well-nourished young girl with pain localized in the right lower quadrant, together with guarding and rebound tenderness. Rectal examination was normal. The patient's white blood cell count was 10,000. A diagnosis of acute appendicitis was made and the patient was taken to the operating room. At laparotomy, an area of infarcted omentum approximately the size of a fifty-cent piece was found. This was removed, along with the appendix. The patient made an uneventful recovery.

Case 2.—A 24-year-old male was seen at the Veterans Administration Hospital with a history of abdominal pain of five days' duration. The pain had started in the epigastrium but later had localized to the right lower quadrant. There was no nausea or vomiting and no history of abdominal trauma.

Examination of the abdomen revealed right lower quadrant pain together with rebound tenderness. The white blood cell count was within normal limits. A diagnosis of acute appendicitis was made and the patient was taken to the operating room where laparotomy revealed an area of infarcted omentum measuring approximately five by five cm. This was removed, along with the patient's appendix. Postoperatively he did well and made an uneventful recovery.

Case 3.—A 26-year-old white male developed abdominal pain together with anorexia approximately three days prior to admission to the VA Hospital. There was a history of trauma to the right upper quadrant one week previously.

Physical examination revealed a well-developed, well-nourished white male with right upper and lower quadrant pain together with rebound tenderness. Rectal examination was normal. The patient's white blood count was 11,400. A diag-

*Treated by one of the authors (RCB) at the Fort Gordon Army Hospital Special Treatment Center, Augusta, Georgia.

The Authors

- **Gabriel Al-Hajj, M.D.; Raymond C. Bonnabeau, Jr., M.D., William C. Dressler, M.D., and Mansour Jadalizadeh, M.D., Departments of Surgery, West Virginia University School of Medicine, Morgantown, and Veterans Administration Hospital, Clarksburg.**

INFARCTED OMENTUM SIMULATING ACUTE APPENDICITIS

THREE CLINICAL CASES

Case	Age	Sex	Trauma	Duration (Days) and Location of Pain	Operative Findings	Followup
1	8	F	No	1 Day - RLQ	Infarcted Omentum	Clinically Well
2	24	M	No	5 Days - RLQ	Necrotic Omentum	Clinically Well
3	26	M	Yes	3 Days - RUQ and RLQ	Hemorrhagic Omentum	Clinically Well

RLQ - Right lower quadrant, abdomen.
RUQ - Right upper quadrant, abdomen.

nosis of acute appendicitis was entertained but due to the history of trauma the etiology of the pain being secondary to intra-abdominal injury also was considered. Laparotomy was performed. An area of infarcted omentum was found measuring approximately ten by five cm. This was removed, together with the patient's appendix. Postoperatively the patient had a smooth and uneventful course.

Comment

The three cases reported in this paper represent cases of infarcted omentum that clinically presented as acute appendicitis. Significantly, only one patient (Case 3, Table 1) gave a history of abdominal trauma either prior to or following laparotomy after the diagnosis had been firmly established.

Historically, abdominal trauma is especially difficult to elicit in children, where the traumatic episode might be considered "just another fall," and therefore its significance overlooked by child and parents alike.

Since the diagnosis in these cases cannot be made preoperatively by the clinical picture alone, laparotomy with abdominal exploration usually is necessary. Excision of the damaged omentum will result in complete cure.

Summary

Three cases of infarcted omentum simulating acute appendicitis are reported.

While the condition can be suspected preoperatively, definite diagnosis can be made only by exploratory laparotomy.

Manuscript Information

Manuscripts to be presented for publication in *The West Virginia Medical Journal* should be typewritten, triple-spaced, on one side only of firm (not onion skin or flimsy), standard letter sized (8½ by 11 in.) white paper. Wide margins (at least 1¼ in. on left) should be left free of typing. On the first or title page should be shown the title of the article, the name (or names) of the author, and his degrees. Pages should be numbered consecutively, the page number being shown in the right upper corner along with the surname of the author.

Authors are requested to submit a carbon copy with the original or retain same in the event the manuscript is lost in transmittal.

Illustrations should be numbered and their approximate locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for cuts should be done in black (India) ink on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it. The author will bear the cost of all over two one-column halftone cuts.

All scientific material appearing in *The Journal* is reviewed by the Editorial Board. Manuscripts should be mailed to The Editor, West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

Medical Grand Rounds

From the West Virginia University Medical Center

Edited By

Raymond B. Weiss, M. D.
Assistant Professor of Medicine

Extrinsic Allergic Alveolitis (Hypersensitivity Pneumonitis)

(Case Report)

N. Leroy Lapp, M.D., Associate Professor of Medicine, West Virginia University Medical Center.

A 58-year-old male (F.P.) was admitted to West Virginia University Hospital on June 6, 1973 with the chief complaint of severe shortness of breath. Two days prior to admission he and his son had replaced an approximately 16-year-old commercial air conditioning unit that was "extremely dusty" and contained a fine, black dust around the coils. That evening upon returning home from work he noticed some exertional dyspnea that prohibited his doing some gardening as was his usual custom in the evening after work. Over the course of the next 48 hours the dyspnea became progressively worse and was associated with cyanosis of the lips, ear lobes and finger-nail beds. At the time of admission he appeared in acute respiratory distress, breathing at a rate of 40 breaths per minute, was using accessory muscles of respiration, and had retraction of the suprasternal space. The lips, ear lobes and finger-nail beds were deeply cyanosed, but no finger clubbing was evident. There was no evidence of raised jugular venous pressure or of edema of the extremities.

Examination of the thorax revealed symmetrical expansion, no dullness to percussion, but diffusely scattered fine to medium rales over both lower zones posteriorly and the mid to lower zones laterally and anteriorly on both right and left. The heart tones were of normal intensity, and no murmurs or gallop rhythms were audible. The heart rate was 120 per minute and regular. Admission postero-anterior chest film (Figure 1) revealed a diffuse, acinar-filling-pattern parenchymal infiltration involving nearly two-thirds of the right and approximately one-third of the left lung in a peri-hilar distribution. The heart silhouette did not appear to be enlarged, and there was no obvious dilation or prominence of the upper lobe veins. Dense, rounded, calcifications were evident in both hilar areas along with the right paratracheal region and posterior to the trachea. Analysis of arterial blood obtained with the patient breathing room air revealed a P_{O2} of 37 mm. Hg., a P_{CO2} of 25 mm. Hg., a pH of 7.43 units, and a calculated saturation of 73 per cent. Repeat measurements approximately 30 minutes after instituting oxygen via a tight-fitting mask with six liters per minute flow were P_{O2} 58 mm. Hg., P_{CO2} 30 mm. Hg., pH 7.48 units, and a calculated saturation of 90 per cent.

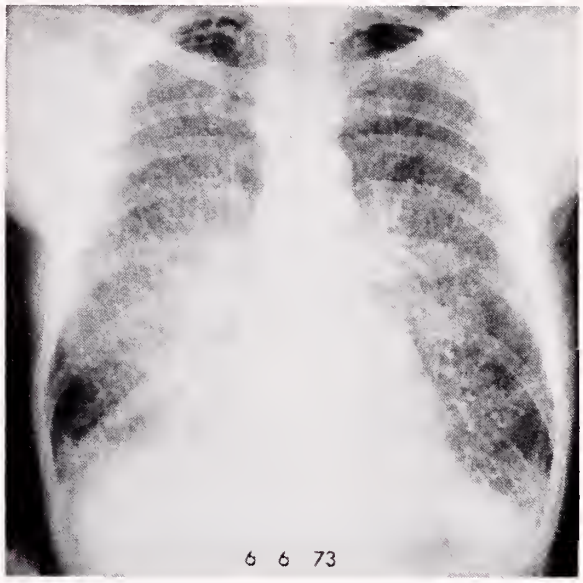

Figure 1. Admission postero-anterior chest film obtained on patient F.P.

A tentative diagnosis of extrinsic allergic alveolitis was made, and the patient was started on Prednisone with 100 mg. administered within the first 24 hours and 60 mg. daily thereafter. Striking clinical improvement was noted within several days, although the infiltrations evident on the chest radiograph cleared more slowly. Spirometry, lung volumes and single breath carbon monoxide diffusing capacity were measured on June 15, 1973 (Table 1), nine days after admission and at a time when the patient was clinically better but still had some infiltrations on the chest radiograph (Figure 2). The pulmonary function tests were interpreted as showing mixed restrictive and obstructive impairment with a moderately severe diffusion impairment.

The chest radiograph obtained on the 21st day of hospitalization (Figure 3) demonstrated complete clearing of the acinar-filling pattern of infiltration. A few micronodular shadows in both mid-lung fields and the previously described calcifications remained which were attributed to the patient's earlier exposure to silicates during his 10 to 12 years of employment as a grinder in a bathroom fixture factory.

Blood serum samples drawn on the day of admission were subsequently shown to demonstrate strong precipitin bands to antigens derived from *Thermoactinomyces vulgaris* by electro-immunodiffusion studies.[1] Cultures of some of the black dust obtained from the coils of the air conditioner unit on which the patient had worked just prior to his illness demonstrated growth of a similar microorganism at 56°C. but not at 37°C. or room temperature.

Discussion

This case illustrates the typical course of extrinsic allergic alveolitis, a term that has been applied to a growing number of conditions in which the inhalation of organic dusts results in hypersensitivity reactions at the alveolar level.

Bernardino Ramazzini, the father of occupational medicine, was the first to allude to this disease syndrome variously known as allergic alveolitis or hypersensitivity pneumonitis. As early as 1700 he described the classical example of this group of diseases, what is now known as "farmer's lung." In his time, the condition was observed among "sifters and measurers of grain."[2]

Farmer's lung was first described in its current form in 1932, owing to its association with moldy hay.[3] Since then, a large number of conditions have been reported which have a similar clinical presentation and pathogenesis to that of farmer's lung (Table 2). In each there is an association either with occupation (farmer's lung, bagassosis), hobby (pigeon and budgerigar fanciers), iatrogenic exposure (pituitary snuff), or environmental (contaminated air conditioners) exposure.

Robert G. Burrell, Ph.D., Professor of Microbiology, West Virginia University Medical Center.

Immunology

Four main forms of immunologic response that are known to lead to injury may occur in the lungs following the inhalation of organic dusts. In atopic individuals the airways may be chiefly

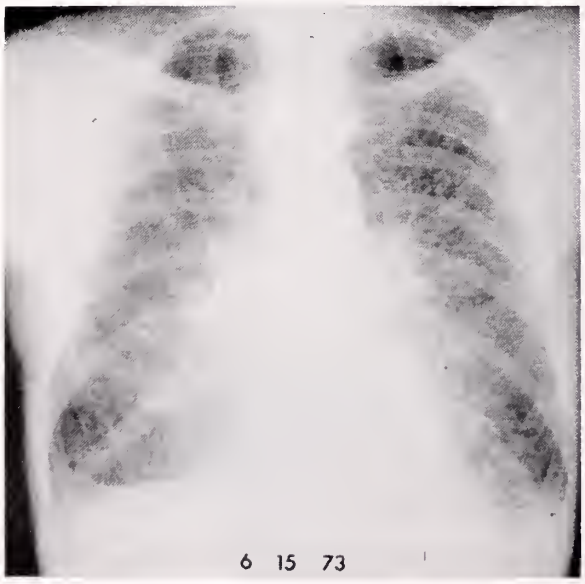

Figure 2. Postero-anterior chest film on F.P. obtained on ninth day after admission.

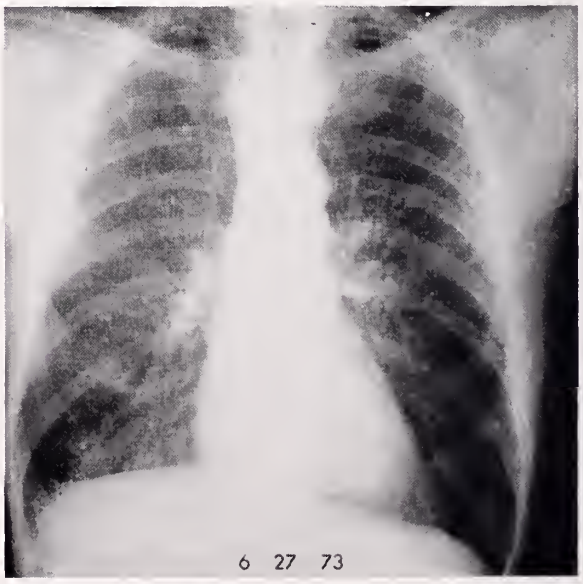

Figure 3. Postero-anterior chest film on F.P. obtained on 21st day after admission.

Table 1

Lung Volumes and Diffusing Capacity

Test	Observed	Predicted	% Predicted
Total Lung Capacity (L)	5.79	5.80	100
Residual Volume (L)	2.05	1.80	114
RV/TLC x 100	35	31	
Vital Capacity (L)	3.74	4.01	93
Diffusing Capacity (ml. x min.-1 x mmHg.-1)	12	28	43

Spirometry

Test	Observed		Predicted
Forced Vital Capacity (L)	3.56	(3.42)*	4.01
Forced Expiratory Volume One Second (L)	2.07	(2.02)	3.06
$FEV_{1.0}/FVC$ x 100	58	(59)	76
Maximal Voluntary Ventilation (L/M)	82	(96)	131

* Value in parenthesis indicates after Isoproterenol.

Table 2

Types of Extrinsic Allergic Alveolitis

Condition	Source of Antigen	Known or Suspected Agent(s)
Farmer's lung	Moldy hay	**Micropolyspora faeni** **Thermoactinomyces vulgaris**
Bagassosis	Moldy bagasse	**T. vulgaris**
Maple-bark pneumonitis	Moldy maple-bark	**Cryptostroma corticale**
Mushroom worker's lung	Mushroom compost	**M. faeni** and **T. vulgaris**
Malt worker's lung	Moldy barley or malt	**Aspergillus clavatus** **Aspergillus fumigatus**
Sequoiosis	Moldy sawdust	**Graphium**
Granary worker's lung	Infested grain flour	**Sitophilus granarius** (grain weevil)
Bird fancier's lung	Avian excreta, feathers	Serum protein and excreta
Pituitary snuff-taker's lung	Pituitary powder	Proteins in porcine and bovine posterior pituitary extract
Air conditioner lung	Mold on coils	**T. vulgaris**
Cheese washer's lung	Moldy cheese	**Penicillium casei**

Modified from:

Pepys, J.: Hypersensitivity diseases of the lungs due to fungi and organic dusts. Monographs in Allergy **4**:1-147, 1969.

Table 3

Summary of Characteristics of Different Types of Immune Injury

	Type I	Type II	Type III	Type IV
Characteristic of immune effector	Reagin (IgE) dependent	Cytotoxic antibodies	Immune complexes plus complement	Cell mediated (lymphocytes)
Time of onset of skin test and gross appearance	Within seconds to minutes. Subsides within 1-2 hours	Not applicable	4-6 hours, maximal at 12, resolved by 24	6-8 hours, maximal at 24-48
	Wheal and flare		Inflammatory swelling; leads to necrosis only in extreme cases	Erythema and induration leading to necrosis
Histology of skin test	Little change other than hyperemia and edema; possibly some eosinophiles	Variable depending on target cell	PMN infiltrate, mononuclear cuffing perivascularly. Arteritis maybe necrotizing	Perivenous mononuclear infiltrates between deep dermis and muscle
Response to therapy	Antihistamines	Steroids, immunosuppressants	Steroids, disodium cromoglycate	Steroids

affected giving rise to asthmatic symptoms that are mediated by tissue fixing, nonprecipitating, reaginic antibody of the IgE class, the so-called immediate or Type I allergy. Nasal stuffiness, or uncomplicated bronchial asthma, resulting from mildewed or moldy materials would be of this type. Type II reactions are those in which the antibody reacts either with the cell itself or with antigens adsorbed to the cell in such a way that the cell is damaged or lysed. Type III reactions are called immune complex reactions because they are due to certain amounts of precipitating, nonreaginic antibody-forming soluble complexes with excessive amounts of antigen. These soluble complexes fix complement and attract neutrophiles which subsequently release their lysosomal enzymes causing the damage to tissues. Unlike the other three types, Type IV is cell mediated and is best exemplified by the classical tuberculin reaction wherein sensitized lymphocytes react with antigen and cause the release of certain mediators which in turn result in the tissue damage. These reactions are summarized with additional differential characteristics in Table 3.

All of these types of immune injury may be involved in the pathogenesis of hypersensitivity pneumonitis, although there is very little evidence for Type II, cytotoxicity reactions. Reaginic sensitivity may accompany hypersensitivity pneumonitis, but is not responsible for the major symptoms or pathology as this form of sensitivity often may be absent from the disease. At the present time, the bulk of opinion favors a Type III mechanism as accounting for the disease. Rather than giving rise to asthmatic symptoms, this type of reaction is associated with shortness of breath and abnormalities of gas exchange owing to inflammatory changes occurring at the alveolar level caused by the cellular response to the immune complexes. Some recent evidence suggests that Type IV delayed hypersensitivity responses also are a factor in disease production. It has been suggested that hypersensitivity pneumonitis is a disease spectrum, varying according to what immunologic components there are and to what degree they go in to make up the over-all response in a given situation.

Microbiology

The inciting agents involved in diseases of this type are interesting from several standpoints. As the name implies, the thermophilic actinomycetes are microorganisms intermediate between the size of true bacteria and higher fungi and which are capable of growing only at elevated temperatures (45-56°C). Indeed, these microorganisms are not even capable of growing at 37°C. and, hence, cannot be considered infective even though they may be demonstrated histologically and occasionally even recovered from tissues by culture. Their small size of one-half to 1 μ allows them to be inhaled into the deeper airway passages including the alveoli. In nature they are the result of the fermentation of moist organic materials. As microorganisms begin the process of decay of such materials, the temperature often rises, especially in the center of well-insulated material such as silage or compost. At this point the thermophilic microorganisms begin growing abundantly, producing millions of spores. If this material is subsequently dried, and if conditions result through occupational manipulation which cause them to become airborne, humans exposed to such an environment breathe in huge numbers of these spores. If the individuals are properly sensitized immunologically, pathology results.

Doctor Lapp

Clinical Features

The common pattern of clinical features in extrinsic allergic alveolitis contrasts strikingly with that of atopic asthma. Systemic symptoms of dyspnea, cough, general malaise, chills, fever, anorexia, weight loss and sometimes cyanosis often occur in the acute exacerbations of the disease within a few hours of exposure to the offending agent. In the chronic phase, increasing dyspnea and cyanosis develop insidiously over the course of months or years of exposure.[4] While the acute form of the disease is generally self-limited, or responds promptly to removal from exposure to the offending dust and appropriate therapy, repeated exposure over the course of months and years may lead to permanent pulmonary disability.[2] The most commonly encountered physical findings either in the acute or chronic phase are the fine crepitations heard principally at the bases, but which may be present throughout the lung fields.

The pulmonary functional abnormality encountered usually is a restrictive ventilatory impairment associated with impairment of gas transfer and a decreased lung compliance. Airways obstruction is not a feature of this disease unless the patient has been a cigarette smoker or has coexisting obstructive airways disease.

The radiographic abnormality in the acute phase of the disease usually presents as widely distributed micronodular shadows similar to those seen in sarcoidosis and some of the mineral pneumoconioses. In the more subacute and chronic forms of the disease the features are those of reticulonodulation with a honeycomb

appearance similar to that seen in the advanced stages of fibrosing alveolitis (diffuse interstitial fibrosis).

In the early stages of the disease the lungs show infiltration of the alveolar walls with polymorphonuclear leukocytes, lymphocytes, plasma cells and epithelioid cell granulomata, the whole picture resembling superficially that seen in sarcoidosis. Variable degrees of fibrosis may be present depending upon the duration of the allergic response. Nearly 25 per cent of patients with farmer's lung in one series demonstrated features of obliterative bronchiolitis.[5]

It is helpful in diagnosing these diseases to have serological and, if appropriate, microbiological evidence for identifying the offending antigen.

Treatment

The first principle in treating extrinsic allergic alveolitis is avoidance of further exposure to the offending antigens. In acute cases in which severe abnormalities of gas transfer occur, supplemental oxygen therapy and a brief course of corticosteriod drugs such as Prednisone may be necessary. Preventive measures to avoid exposure in certain industries is obvious. The use of masks, however, is of little benefit because the spores of the thermophilic actinomycetes and most of the other offending agents are small enough (around one μ) to pass through the interstices of the masks. For the farmer, it may mean meticulous attention to the drying of hay and forage in order to avoid the conditions conducive to molding. Where industrial processes cannot be changed or the process controlled, it may mean the affected subject must leave that industry.

Summary

In summary, the relatively stereotyped immunological response of the lung to organic dusts known as extrinsic allergic alveolitis or hypersensitivity pneumonia, is being diagnosed with increasing frequency. It differs from classical extrinsic asthma in that the gas exchange areas of the lung are the site of pathology rather than the airways. Shadows usually are evident on the chest radiograph, and there are precipitating antibodies present in the serum of subjects demonstrating the disease. Corticosteroids are of benefit in treating the acute, severe response, but prevention of further exposure is the only definitive protection against chronic, disabling, respiratory impairment. Although mainly regarded as a disease of occupation (farmer's lung), the relation may be indirect and often difficult to diagnose without a searching inquiry.

A list of references may be obtained by writing The Journal.

No Seasonal Pattern Found in Suicides

Suicides defy any fixed seasonal or climactic patterns, says a report in the January issue of *Archives of General Psychiatry*, a publication of the American Medical Association. Researchers at Duke University Medical Center and Durham Veterans Administration Hospital analyzed reports of 3,672 deaths by suicide in North Carolina from 1965 to 1971.

They found no major upsurges for special holidays, weekdays versus weekends, months or seasons. Only in days of the week was a difference noted. The highest proportions of suicides during the week were on Mondays. Climate had no impact, when statistics on whether the suicide days were hot or cold, rainy or clear, humid or dry, short or long were compared.

Special holidays—New Year's Day, Easter, Memorial Day, July 4, Labor Day, Thanksgiving and Christmas—also showed no higher rates than other days.

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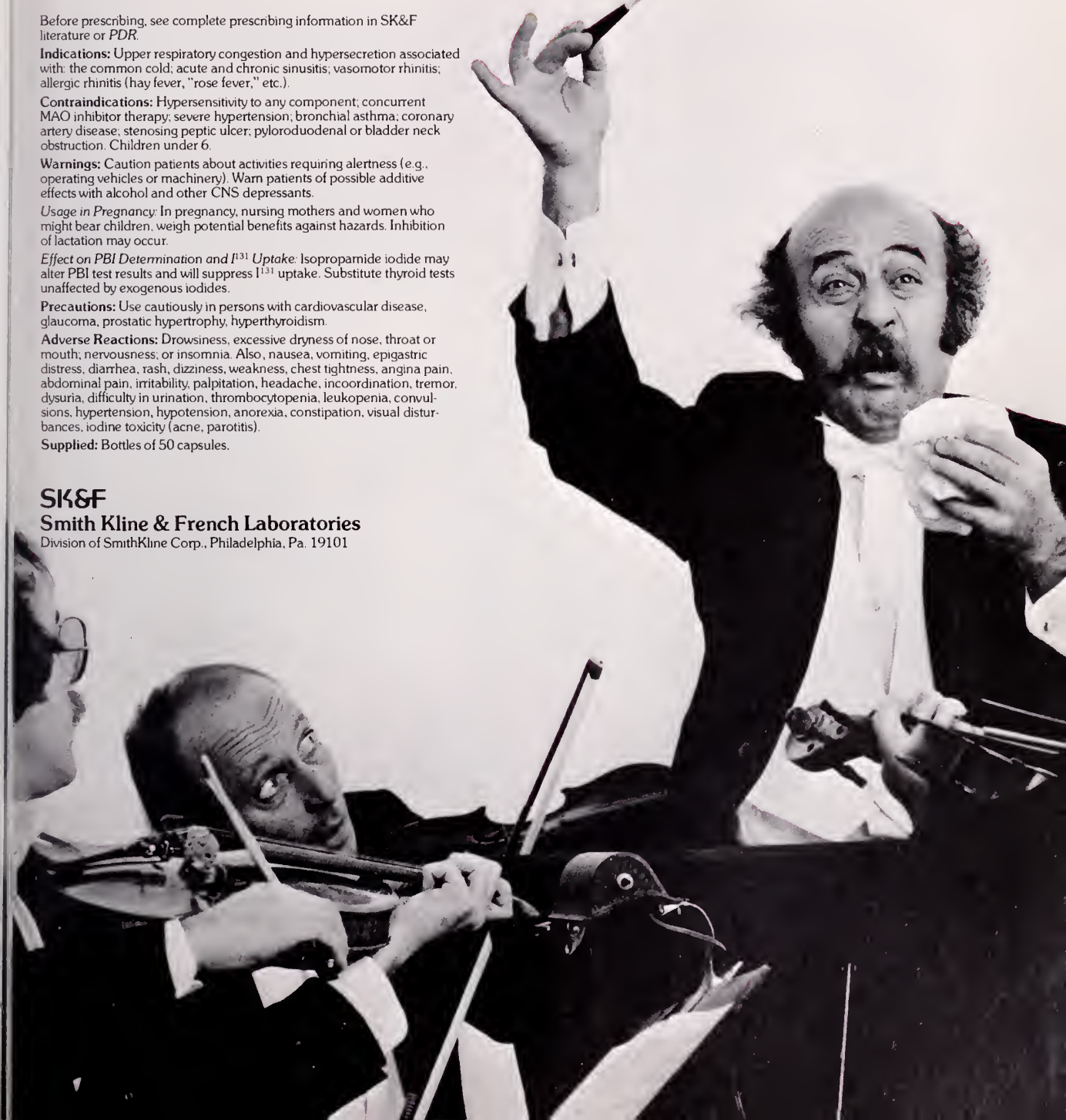

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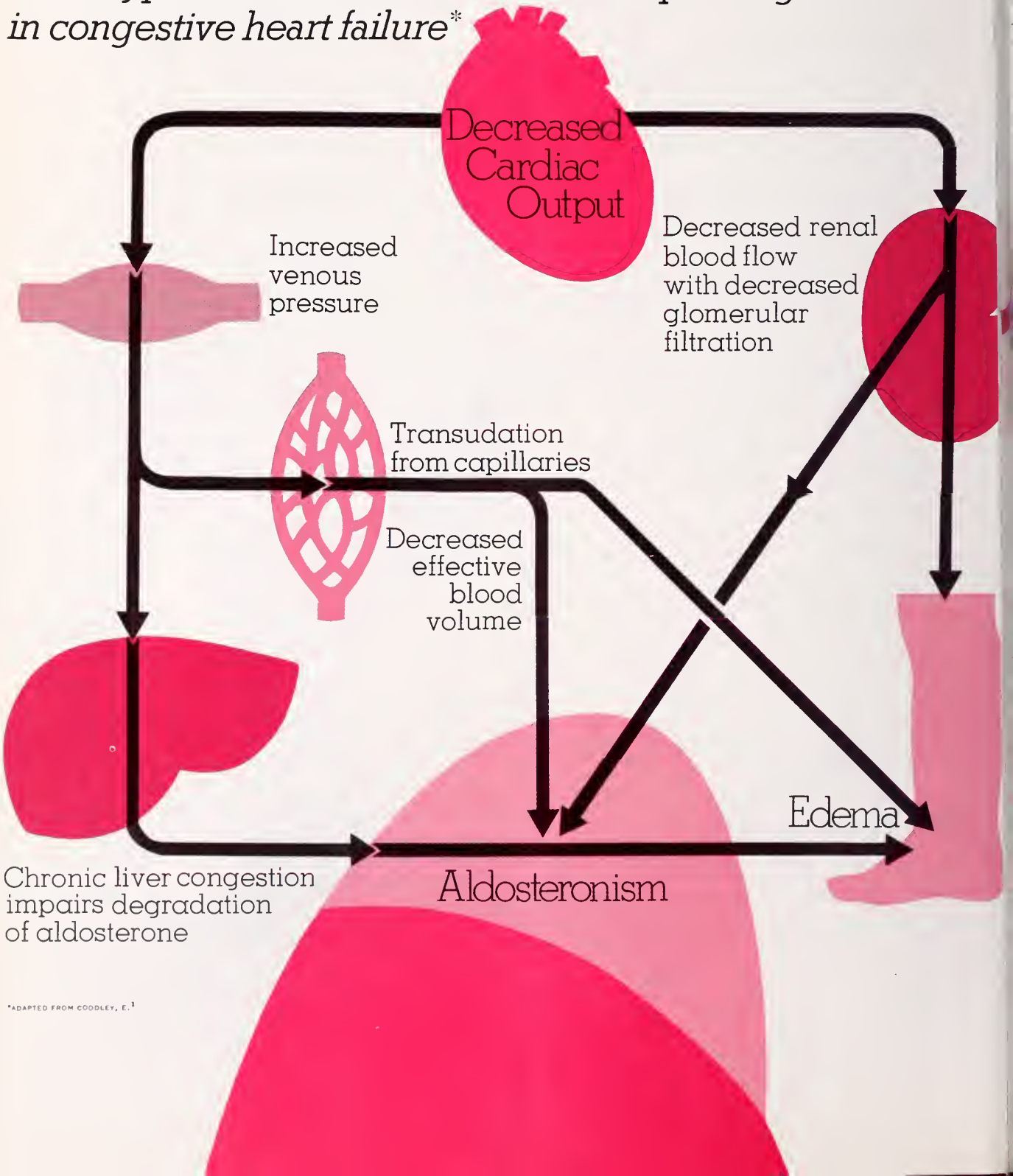

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Indications—Essential hypertension; edema or ascites of congestive heart failure, cirrhosis of the liver and the nephrotic syndrome; idiopathic edema. Some patients with malignant effusions may benefit from Aldactone (spironolactone), particularly when given with a thiazide diuretic.

Contraindications—Acute renal insufficiency, rapidly progressing impairment of renal function, anuria and hyperkalemia.

Warnings—Potassium supplementation may cause hyperkalemia and is not indicated unless a glucocorticoid is also given. Discontinue potassium supplementation if hyperkalemia develops. **Usage of any drug in women of childbearing age requires that the potential benefits of the drug be weighed against its possible hazards to the mother and fetus.**

Precautions—Patients should be checked carefully since electrolyte imbalance may occur. Although usually insignificant, hyperkalemia may be serious when renal impairment exists; deaths have occurred. Hypanatremia, manifested by dryness of the mouth, thirst, lethargy and drowsiness, together with a low serum sodium may be caused or aggravated, especially when Aldactone is combined with other diuretics. Elevation of BUN may occur, especially when pretreatment hyperazotemia exists. Mild acidosis may occur. Reduce the dosage of other antihypertensive drugs, particularly the ganglionic blocking agents, by at least 50 percent when adding Aldactone since it may potentiate their action.

Adverse Reactions—Drowsiness, lethargy, headache, diarrhea and other gastrointestinal symptoms, maculopapular or erythematous cutaneous eruptions, urticaria, mental confusion, drug fever, ataxia, gynecomastia, inability to achieve or maintain erection, mild androgenic effects, including hirsutism, irregular menses and deepening voice. Adverse reactions are infrequent and usually reversible.

Dosage and Administration—For **essential hypertension** in **adults** the daily dosage is 50 to 100 mg. in divided doses. Aldactone may be combined with a thiazide diuretic if necessary. Continue treatment for two weeks or longer since an adequate response may not occur sooner. Adjust subsequent dosage according to response of patient.

For edema, ascites or **effusions** in **adults** initial daily dosage is 100 mg. in divided doses. Continue medication for at least five days to determine diuretic response; add a thiazide or organic mercurial if adequate diuretic response has not occurred. Aldactone dosage should not be changed when other therapy is added. A daily dosage of Aldactone considerably greater than 75 mg. may be given if necessary.

A glucocorticoid, such as 15 to 20 mg. of prednisone daily, may be desirable for patients with extremely resistant edema which does not respond adequately to Aldactone and a conventional diuretic. Observe the usual precautions applicable to glucocorticoid therapy; supplemental potassium will usually be necessary. Such patients frequently have an associated hyponatremia—restriction of fluid intake to 1 liter per day or administration of mannitol or urea may be necessary (these measures are contraindicated in patients with uremia or severely impaired renal function). Mannitol is contraindicated in patients with congestive heart failure, and urea is contraindicated with a history or signs of hepatic coma unless the patient is receiving antibiotics orally to "sterilize" the gastrointestinal tract.

Glucocorticoids should probably be given first to patients with nephrosis since Aldactone, although useful for diuresis, will not directly affect the basic pathologic process.

For **children** the daily dosage should provide 1.5 mg. of Aldactone per pound of body weight.

References: 1. Coodley, E.: Consultant 12:106-107, 109, 111, 113, 115 (July) 1972. **2.** Thorn, G. W., and Louler, D. P.: Am. J. Med. 53:673-684 (Nov.) 1972.

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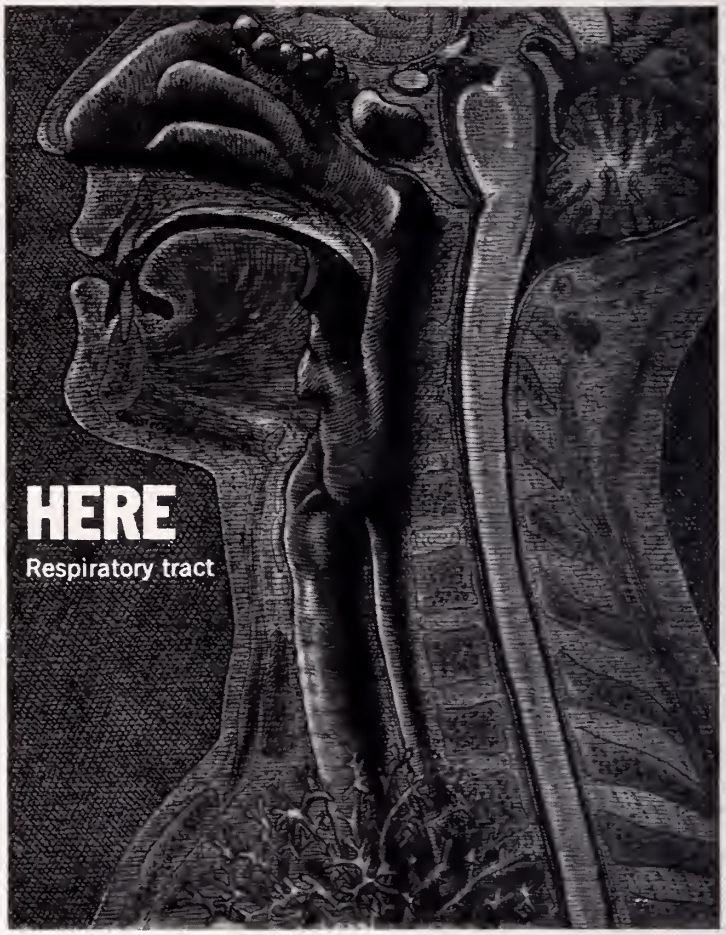

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A message from . . .

The President

A TIP OF THE HAT

A total of at least 300 interested persons attended what must be considered a highly successful Seventh Mid-Winter Clinical Conference which was held in Charleston, January 18-20.

From all comments we have heard, the planners responsible for the three-day session certainly put together a program which appealed to physicians, nurses and other related health personnel. It was indeed pleasing to note that the public session on "The Battered Child" attracted approximately 250 persons while a concurrent session on PSRO was well attended by physicians.

It would be most difficult to single out any individuals or organizations for their splendid cooperation in making the three-day meeting a success. I should, however, like to commend the members of the Woman's Auxiliary to the Kanawha Medical Society for taking charge of the public session as well as making sure the social function on Saturday night was a real treat.

Also, special thanks are due to Drs. Ralph H. Nestmann and Joseph T. Skaggs—Co-Chairmen of the Conference. We hope these two gentlemen will once again agree to serve in the same capacity for the 1975 session. They have worked extremely hard in recent years to make the Mid-Winter Conference one of the highlights of the year for physicians and their families throughout the State.

Tom McCoy

A. Thomas McCoy, M. D., *President*

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EDITORIALS

SOME THOUGHTS ON SEXUALITY

The early publications of Masters and Johnson are thought by many to have heralded the dawn of "modern" attitudes toward sexuality. For many years, one has been able to note an increasing number of publications and writings dealing with human sexuality.

During this same period the so-called "relaxed attitude" toward sexual behavior has developed and broadened. Permissiveness and sexual activity on college campuses, a scandal of the 60's, has become an accepted norm in the 70's. Emancipation from the sense of guilt and the use of sexual activity as a means and evidence of self-expression appear to have been the primary objectives of the "new morality." The latter concept has pervaded teaching and literature in the fields of psychology and religion, extending into the highest organizational structures of established religion in this country.

Matters relating to obscenity and pornography were presumably settled by a Supreme Court decision during the 60's, which gave blanket immunity from prosecution to publishers of sexual materials, audio-visual presentations, movies, etc. It would appear that, now that Sex is official and officially a public matter, there is to be no control over publications depicting it in whatever fashion the authors choose. The subject of sexuality has been introduced in the school systems over the country in grades as early as the first. Courses in human sexuality apparently abound in college curricula. A throw-away publication entitled "Human Sexuality" has been received by physicians and others for several years on a monthly basis.

The question of where the medical profession stands in relation to this subject appears to be somewhat moot at present. This year, for the first time, the writer saw at national meetings in the commercial exhibits, the presentation of audio-visual aids, promoted for use in classroom presentations and for office management of problems in human sexuality.

A particular display at the AAFP meeting in Denver presented a 10-minute abstract of four films available from a particular company for rent or sale to interested individuals and organizations. The booth was seldom without a line of doctors waiting their turn in the five-seat viewing area. The films dealt with intercourse, coital position, teaching methodology of sensate focus, and "insights." If we are to believe the detail man at the booth, courses using these films are taught in numerous schools and colleges as well as at least one seminary.

With particular reference to the situation as outlined above, there may now be some things that should be said. Physicians are called upon to

treat a variety of conditions related to sexual activity. The current "openness" on sex may have led many to conclude that now that sex is out in the open, all related problems will be dealt with easily. Current attitudes toward diagnosis and treatment, if the signs are being correctly interpreted, are being pretty firmly based on anatomy and physiology. In short, sex now appears generally to be considered analyzable, dissectable, and, by various means—especially the audio-visual route—susceptible to "normalization" for given individuals and couples. In this scheme of things, expression and gratification of one's sexuality are made to appear as ends in themselves; and if this *is* the case, serious errors may have been committed or be in the making.

The view that sexuality does *not* lend itself to scientific dissection and analysis may be a minority view, or it may even be a view held by a very silent majority. In any case, the proponents of this view are strangely silent, if they are in the majority.

In spite of our age of enlightenment, there is a valid doubt that the current binge is going to turn out to be the cure-all for sexual hangups its proponents claim. It is one thing to counsel concerning problems of a married couple in search for conjugal satisfaction. The writer submits that it is quite another thing to view nude men and women engaging in various aspects of sexual relations. It is highly questionable, at best, whether any normally oriented individual is able to view with complete objectivity any such portrayal, either in a teaching setting or in personal counseling.

In the current uproar over pornography, the question of the eroticism of any given material is emphasized. Artistic value is cited as a valid excuse for portrayal of sexuality in action; likewise with informational value of material apparently intended for teaching and for counseling. The definition of pornography is rather flimsy. The classification of sexual material into categories of teaching, counseling or erotic arousal may be highly deceptive. Use of these materials in counseling and treatment by the medical profession could ultimately be quite destructive if its proponents—as many of us believe—are wrong. If there be a spiritual component in men and women, the emphasis on sex's physicality to the exclusion of its intangible qualities could result in ultimate tragedy for individuals. From this standpoint, the medical profession might do well to go slow in acquiescing to the entirely materialistic concept of human sexuality.

PAUL DUDLEY WHITE, M.D.

Dr. Paul Dudley White, the renowned cardiologist, died in Boston October 31, 1973 at the age of 87. He was a physician of national and international fame. It is not in the province of this essay to review the many honors he received for his contributions to cardiology or to comment in detail on his standing in the medical profession. These are well known and the medical journals and newspapers have covered them adequately. This editorial will dwell briefly on some of Doctor White's experiences in West Virginia.

The writer of this editorial first became acquainted with Doctor White in 1919, when as a medical student in Boston he served as a volunteer for some electrocardiographic studies Doctor White was making. The latter was a young man —32 years old—and an instructor in medicine at the Harvard Medical School. The electrocardiogram was taken in the Massachusetts General Hospital; this volunteer did not appreciate then that Doctor White would become one of the world's outstanding cardiologists. Throughout the years occasions arose to meet and talk or correspond with him.

Doctor White made a number of trips to West Virginia and seemed to enjoy his visits. On one occasion he came to Morgantown to present an address before the chapter of Phi Beta Kappa at the University. He spoke on the prevention of heart disease to a large and appreciative audience.

Quite early in his career he gave a talk before a group of physicians in Clarksburg. It appeared that a distinguished physician from Boston had been invited, but at the last minute found he could not go so he asked Doctor White to substitute for him. The latter in telling about it explained that this seemed like an important engagement to him and he took it seriously. It was the first time he had made such a talk outside his home state. He wished to please his audience and also discuss certain medical problems which would be helpful to the physicians. Undoubtedly he gave a good account of himself as was his habit. Although this occurred many years ago, it is possible that there are a few physicians in Clarksburg or its environs who may remember it.

On one of Doctor White's visits to Morgantown mention was made of the death of a Wheeling surgeon who had been a famous athlete. Although not an old man he died one day on the golf course of a heart attack; his death was quite unexpected. Knowing that Doctor White be-

lieved firmly in exercise as an aid in the prevention of coronary heart disease, the author of this essay purposely remarked that a life of exercise evidently had not helped this surgeon. Quick as a flash Doctor White replied, in effect, to think how short his life might have been had he not exercised.

In summary, Dr. Paul Dudley White was a highly intelligent man and possessed many talents: a scholar, a teacher, an author, an outstanding clinician, a clinical investigator, and a lucid and precise speaker. Furthermore, he possessed a charming personality, and had many friends in other countries. He will be greatly missed in the United States and it will indeed be a long time, if ever, before his equal will appear. We are grateful that he lived so long among us.

PITFALLS IN WRITING ENGLISH

The use of good English is the mark of a cultured man. If good English is used in the home, the children will, as a rule, speak correct English because this is what they have been accustomed to hear. The physician due to his long formal educational training is generally regarded as a cultured individual, and even if he did not hear good English spoken in his home, his experiences in college and the speech of many of his constant associates doubtlessly played an important part in making him appreciate correct English.

Even though a physician is well educated and presumably considered a cultured person, he does at times make mistakes in English both in writing and speaking. Rather often, for example, he seems unsure whether a word takes a singular or plural verb. Two words which especially seem to trouble him are "data" and "none." The word "data" is always plural and "none" is often singular. Many people do not appreciate this. Another frequent error is the misuse of the word "perfect." Perfect belongs to the group of words that express absolutes and does not admit of a comparison. To use the expression "more perfect" is not only ungrammatical but meaningless. A thing is either perfect or not perfect.

Unfortunately, there are words, although spelled and pronounced similarly, have more than one meaning; words, for example, such as "bear" and "conceive." These often cause difficulty for persons not entirely familiar with the English language, and may cause embarrassment.

The story is told of an educated and cultured Latin diplomat, who attempted to explain to a small group of his English-speaking friends that his wife was unable to have children. In explaining that his wife could not become pregnant he stated that his wife was absolutely "impregnable." He noted that this caused a faint smile on the faces of his friends and he tried again to explain the situation and stated that what he meant was that she was simply "inconceivable." He still felt that this explanation was not clear and with a final heroic effort he remarked she is really "unbearable."

All the words he used are acceptable English and the story is not told to belittle the Latin diplomat, but simply to point out that words which have more than one meaning may produce certain difficulties. It must be remembered that if we were called upon to explain some matter in a foreign tongue, we probably would make equally ludicrous blunders.

In the final analysis, all of us are prone to make mistakes in English grammar, both in speaking and writing. Every effort should be made to overcome our errors and our feelings should not be hurt if attention is called to them by some well-meaning friend.

Snowmobile Noise Causes Deafness

The blasting noise of a racing snowmobile causes marked deafness among drivers and pitmen at the race track, and even is loud enough to cause some hearing loss among nearby spectators, says a report in a current issue of *Archives of Otolaryngology*.

Manufacturers of snowmobiles are aware of the noise problem and are continually making efforts to reduce engine noise, says the report from two investigators at Central Michigan University, Mt. Pleasant, Michigan.

Despite efforts by the industry, 1971 and 1972 model snowmobiles are still loud enough to be a hazard to hearing. But the really blasting noise comes from the racing machines that have been "souped up" to go faster, with a consequent increase in the already high noise level, say Fred H. Bess, Ph.D., and Robert E. Poynor, M.A.

The investigators recommended that the snowmobile industry develop helmets that will protect the ears from the loud sound, as well as offer crash protection. Present helmets are crash helmets only, they say. They also urge promoters of snowmobile races to arrange seating so that spectators are at least 18 meters, or about 16 yards, from the track.

The study was conducted on 21 racing drivers and five snowmobile mechanics. Average age of the drivers was 28 years, but their hearing loss averaged that of men between the ages of 51 and 57 years. Data was collected at Michigan's largest snowmobile racing event, the International 500 at Sault St. Marie.

GENERAL NEWS

Sen. Robert C. Byrd Honor Guest At 107th Annual Meeting

The Program Committee arranging the 1974 Annual Meeting is pleased to announce that Sen. Robert C. Byrd has accepted an invitation to be an honor guest at the Association's 107th Annual Meeting which will be held at The Greenbrier in White Sulphur Springs, August 21-24.

Sen. Robert C. Byrd

Dr. J. Hugh Wiley, Chairman of the Program Committee, said that Senator Byrd will be the keynote speaker at the first general scientific session on Thursday morning, August 22. Senator Byrd will deliver "The Thomas L. Harris Address" which was established as a result of a bequest in the will of the late Dr. Thomas L. Harris.

Doctor Harris, who served as president of the State Medical Association in 1945, established the trust fund in an effort to enhance the quality of the programs for future annual meetings of the Association.

Senator Byrd of Sophia, Raleigh County, was elected Majority Whip of the United States Senate in 1971 and was unanimously reelected in 1973. He was graduated cum laude with a J.D. degree from the American University and has held more legislative elective offices than any other individual in the history of West Virginia.

He served two terms as a member of the West Virginia House of Delegates and one term as a member of the State Senate. In 1952, he was elected to the first of three terms as a member of the U. S. House of Representatives and has served as one of two West Virginia members of the United States Senate since 1958.

In 1964 he was reelected to the U. S. Senate by the greatest numerical vote and numerical majority ever accorded a West Virginia candidate. During the 1970 primary he received the highest percentage (89 per cent) of votes ever received by a candidate in a statewide contested election. That same year he carried all 55 counties in the 1970 general election for the first time in the State's history and received the highest percentage (78) of votes ever received by a candidate in a West Virginia statewide contested general election.

He was elected Secretary of the Senate Democratic Conference in 1967 and also serves as a member of the Appropriations Committee, Judiciary Committee, and the Committee on Rules and Administration.

Interesting Scientific Program Arranged

Doctor Wiley also announced that some of the nation's most prominent physicians and surgeons have accepted invitations to present papers at the three general scientific sessions which will be held on Thursday, Friday and Saturday mornings. Names of the other guest speakers will be announced in future issues of *The Journal.*

Business Meetings Scheduled

The pre-convention meeting of the Council will be held on Wednesday morning, August 21.

The first session of the House of Delegates will be held on Wednesday afternoon and the final session on Saturday afternoon, August 24.

Nursing Director Named

Mrs. Laurie Tully, former area supervisor with the West Virginia Department of Health's Bureau of Public Health Nursing, has assumed new duties as acting Director of Nursing for the State Department of Welfare's Division of Crippled Children's Services, Welfare Commissioner Edwin F. Flowers announced.

Doctors Earn 700 CME Hours In VOSAS Participation

The 110 West Virginia physicians who participated in the experimental Voluntary Office Self-Audit Service (VOSAS) continuing medical education project in the July 1, 1970-June 30, 1973, period earned about 700 hours of credit they can put to good advantage.

Those hours may be credited toward the 1973 American Medical Association's 1973 Physician's Recognition Award in Category 5(c), embracing patient care review.

VOSAS has been operated under the funding and management control of the West Virginia Regional Medical Program in cooperation with the West Virginia State Medical Association and its Committee on Medical Education and Hospitals.

A key objective has been to determine by representative sample if physicians would choose self-examination of performance with the use of peer reviewers of their choice as a continuing medical education tool.

Also tested have been the validity of using physician's office records as a source of performance data; the use of medical records technicians to perform such functions as audits of records data; and the technical process of reviewing criteria physicians themselves set for diagnosis and treatment of disease areas they choose for study.

The operational aspects of the three-year initial VOSAS effort now are being concluded, with a subsequent evaluation expected to be one of the principal medical education assignments to be undertaken by the recently established West Virginia Medical Institute, Inc.

The 60 physicians who volunteered as project participants represented 70 per cent of those asked, and about five per cent of the office-based West Virginia practitioners. Several of those physicians also served as reviewers, along with 50 others who generally were nominated for that function by medical specialty societies.

Future evaluation of VOSAS will be particularly concerned with its potential, in principle or from other standpoints, as an effective means of meeting continuing education needs which might be identified or brought about by the Professional Standards Review Organization (PSRO) law soon to be implemented across the nation.

The 1973 AMA Physician's Recognition Award will be granted for a minimum total of 150 credit hours of continuing medical education activities earned over the three-year qualifying period which ended last June 30.

Of the 150 hours, 60 must be earned in Category 1, embracing programs with AMA accredited sponsorship. Up to 22 hours may be earned in Subcategory 5(c), the patient care review area into which the VOSAS program falls.

To assist those participating physicians and VOSAS reviewers who desire to apply credit earned toward the Physician's Recognition Award, the VOSAS staff has taken these steps:

—Advised the individual physicians, in what amounts to letters of certification, of the hours VOSAS office records indicate they have spent in either participation or review activities, with proper identification and dates for subjects studied or reviewed.

—Provided the physicians, as enclosures with the letters, with the 1973 Physician's Recognition Award booklet; and application forms for the award.

The physicians have been urged to check the activity certified by the VOSAS office against their own records in order that any corrections they desire can be made.

The Physician's Recognition Award represents a voluntary continuing medical education incentive program, open to all doctors of medicine and osteopathy residing in the United States without regard to AMA membership. During its first four years, approximately 41,000 physicians have been qualified for the award.

Completed application forms for the 1973 award, with a fee of five dollars for AMA members and $10 for non-members, must be submitted to the AMA's Department of Continuing Medical Education prior to May 31, 1974.

Deadline For Heart Research Grant Application March 1

Applications for grants-in-aid for heart research in West Virginia are now being accepted by the American Heart Association, West Virginia Affiliate, from investigators working in the cardiovascular field. The deadline for receiving applications is March 1, according to an announcement by Dr. Robert Gardner of West Virginia University, Chairman of the health organization's Research Committee.

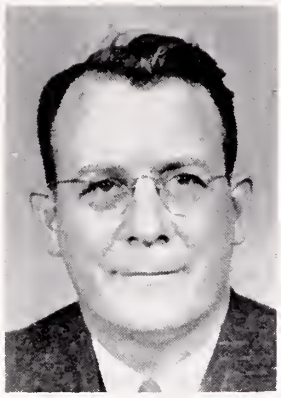
Although no maximum grant has been established, individual requests should not exceed $3,000. Grants are not restricted to any particular discipline. However, the investigator must be qualified and have the facilities available to pursue his work.

Grants are awarded to scientists who need interim or supplementary support for on-going projects or to those who wish to demonstrate by pilot experiments the value of a new project. The program is separate from that of the affiliate's parent organization, the American Heart Association.

Applications and additional information may be obtained by writing to the Executive Director; American Heart Association, West Virginia Affiliate; 211 Thirty-Fifth Street, S. E.; Charleston 25304.

Former Executive Secretary Dies at Age of 76

Mr. Joseph Whitney Savage, who served as Executive Secretary of the West Virginia State Medical Association from 1927 until 1942, died on December 14 in a hospital in Nyack, New York. He was 76.



Mr. Joseph W. Savage

A native of Charleston, Mr. Savage was graduated from West Virginia University and was employed as a reporter for newspapers in Morgantown and Charleston prior to joining the staff of the State Medical Association.

During World War I, he left Charleston High School in his senior year in 1917 to enlist in the Army Air Service and was a pursuit pilot in France before the War ended. He resigned his post with the Association in 1942 and served as Commandant of Cadets at Hondo Army Air Base and Director of Military Training at San Marcos Army Air Base, both in Texas.

He served from 1946 until 1951 as Executive Director of the National Foundation for Infantile Paralysis, and then joined King Features which distributed a syndicated column known nationally as "Mirror of Your Mind." He also wrote articles which appeared in numerous national magazines.

Survivors include his wife, Mrs. Janet Kelly Savage; three sons, Lon, Assistant President of Virginia Polytechnic Institute; Lee, an artist in New York City, and John, a newspaper man in New Jersey; three brothers, Fred C., William and D. Jackson Savage, all of Charleston; a sister, Mrs. Elizabeth Estill of Parkersburg; and several grandchildren. The body was cremated and a memorial service was held in Charleston on January 7.

Three Family Practice Residencies In West Virginia Approved

Three Family Practice residencies in West Virginia were among 18 new Family Practice residencies recently approved by the American Academy of Family Physicians through its Residency Review Committee for Family Practice.

The three approved residencies in West Virginia are the Kanawha Valley Family Practice Program at South Charleston and those at Wheeling Hospital and West Virginia University Medical Center (See story on the "WVU Medical Center News" Page in this issue of the *Journal*).

The 18 new Family Practice residencies bring the total of approved FP training programs to 191.

Dr. John E. Jones Named Dean At WVU School of Medicine

Dr. John E. Jones was officially named Dean for the West Virginia University School of Medicine on January 1. He had been serving as Acting Dean since last July following the resignation of Dr. Frank W. McKee.

John E. Jones, M. D.

Announcement of the appointment was made by WVU President James G. Harlow following the recommendation by a 10-member search committee, which included two students and was headed by Dr. Alvin L. Watne, Professor and Acting Chairman of the Department of Surgery.

"Doctor Jones is uniquely qualified for the position," said Dr. Charles E. Andrews, Provost for Health Sciences at WVU. "He was chosen from among six candidates interviewed by the committee."

Doctor Jones, 43, has been a member of the School of Medicine faculty since 1961 and has served as Chairman of the Division of Metabolism-Endocrinology of the Department of Medicine before being named Acting Dean.

A native of Mt. Pleasant, Utah, Doctor Jones received his M.D. degree from the University of Utah College of Medicine. He interned and served the first 18 months of his residency in internal medicine at the University of Minnesota Hospital. He served for the next 30 months in the Medical Corps of the U. S. Navy and served as Bureau of

Medicine and Surgery liaison to the National Academy of Science.

Doctor Jones returned to Minnesota in 1959 to continue his residency at the VA Hospital in Minneapolis and concluded his specialty training in 1961 at WVU as a United States Public Health Trainee in Endocrinology.

He is a Fellow of the American College of Physicians and holds membership in The Endocrine Society, Central Society for Clinical Research, American Society of Clinical Nutrition, American Institute of Nutrition and the American Federation for Clinical Research.

Author or co-author of more than 30 scientific publications, Doctor Jones has served both as Assistant Chief and Chief of Staff at University Hospital, and during the 1972 sabbatical of Dr. Edmund B. Flink, was Acting Chairman of the Department of Medicine.

Scientific Assembly, AAFP, In Charleston April 5-7

The 22nd Annual Scientific Assembly of the West Virginia Chapter of American Academy of Family Physicians will be held April 5, 6 and 7 in Charleston at the Charleston House, Holiday Inn.

Some 14 physicians will speak at the scientific sessions held during the three-day meeting. The Assembly will open at 8:30 A.M. Friday, April 5, and conclude on Sunday at 12:30 P.M.

There will be a Board of Directors Meeting on Thursday at 7 P.M. and on Sunday at 1 P.M. The House of Delegates will meet on Friday from noon to 1:30 P.M. On Friday evening there will be a cocktail party and on Saturday evening the Annual Banquet beginning with cocktails at 6:00.

Speaking at the banquet will be Donald P. Brown, M. D., Kingwood, President of the State Chapter, and James G. Price, M. D., of Brush, Colorado, President of the national AAFP.

There will be a registration fee of $30 and a banquet and cocktail fee of $12.50 per person. There will be no registration fee for nurses, interns and students.

The Annual Assembly has been approved for 17 hours of credit in Category 1 by the AAFP.

William D. Crigger, M. D., South Charleston, President Elect, is Program Chairman.

Scientific Speakers

Scientific speakers and their topics will be:

Friday: "The Emotional Impact of Chronic Disease in Childhood on the Child and Family"—O. Lee Trick, M. D., Assistant Chairman of the Department of Behavioral Medicine and Psychiatry, West Virginia University School of Medicine, and Resident Director, Charleston Area Medical Center Program; and Mrs. Reita Troum, Assistant Director and Assistant Professor, Director of Family Therapy, Department of Behavioral Medicine and Psychiatry, WVU;

"Common Skin Disorders of the Infant"—Robert A. Hawkins, M. D., Practicing Dermatologist, Charleston.

"Diagnosis of Rheumatic Diseases in the Ambulatory Patient"— George E. Ehrlich, M. D., Professor of Rehabilitation Medicine; Temple University School of Medicine;

"Pros and Cons of Problem Oriented Medical Records in Family Practice"—William A. Stowe, M. D., Dayton, Ohio; and Edward J. Shahady, M. D., Director of the Department of Family Practice, Akron (Ohio) City Hospital;

Saturday: "Differential Diagnosis of Jaundice" —Mitchell A. Spellberg, M. D., Professor of Medicine, Pritzker School of Medicine of the University of Chicago;

"Use of Diuretics in Congestive Heart Failure"—Walter M. Kirkendall, M. D., Professor and Director of the Program in Internal Medicine, University of Texas Medical School, Houston;

"Treatment of Rheumatic Diseases in the Ambulatory Patient"—Doctor Ehrlich;

"Cirrhosis"—Doctor Spellberg;

"Drug Therapy of Hypertension"—Doctor Kirkendall;

"Diagnosis of Thyroid Disease"—Herbert A. Selenkow, M. D., Consultant, Endocrinology and Metabolism Advisory Committee, FDA, Washington, D. C.;

Sunday: "Thyroid Hormones in Clinical Practice"—Doctor Selenkow;

"Outpatient Seminar"—Robert D. Patchell, M. D., Director of Obstetrics, Charleston Area Medical Center; James E. Boggs, M. D., Practicing General Surgeon, Charleston, and John D. Zeedick, M. D., Anesthesiologist, Herbert J. Thomas Memorial Hospital, South Charleston;

"Seminar on Family Practice"—James G. Price, M. D.;

"The Development of Family Practice at West Virginia University and Its Goals"—John W. Traubert, M. D., Director of the Department of Family Practice, WVU;

"The Establishment and Continuation of a Family Practice Residency Program"—Edward J. Shahady, M. D.

Dr. William Morgan Lectures At Florida Institution

Dr. William C Morgan, Jr., of Charleston served as a visiting professor at the University of Miami, Florida, School of Medicine December 5 and 6.

Doctor Morgan gave lectures on ear surgery, and his activities also included rounds, informal discussions with medical students and participation in seminar-type meetings.

Ophthalmology - Otolaryngology State Meeting April 17-20

The National Spring Meeting of the West Virginia Academy of Ophthalmology and Otolaryngology will be held April 17-20 at The Greenbrier, in White Sulphur Springs.

Speakers for the Ophthalmology program will include Drs. Fred C. Blodi of Iowa City, Iowa; Claes Dohlman, Boston; William Havener, Columbus, Ohio; Herbert Kaufman, Gainesville, Florida, and Orkan Stasior, Albany, New York.

Appearing on the Otolaryngology program will be Drs. Beverly Armstrong, Charlotte, North Carolina; Byron Bailey, Galveston, Texas; Vernon Gray, Los Angeles, and Gene Myers, Pittsburgh.

Room reservations should be made directly with The Greenbrier. Checks for the registration fee of $95 should be made payable to the West Virginia Academy of Ophthalmology and Otolaryngology and addressed to J. Elliott Blaydes, Jr., M. D., The Blaydes Clinic, Between North and Frederick on Woodlawn, Bluefield 24701.

The 1973-74 Academy officers are Drs. Claude R. Davisson of Weston, President; M. C. Korstanje, Huntington, Vice President; Nime K. Joseph, Wheeling; Worthy W. McKinney, Beckley, and William C. Morgan, Jr., Charleston, Directors; and Doctor Blaydes, Secretary-Treasurer.

Four Past Presidents of the West Virginia State Medical Association relaxed at a luncheon held during the American Medical Association's Clinical Convention December 2-5 at Anaheim, California. Left to right are Dr. George R. Callender, Jr., of Charleston, now an Alternate Delegate to the AMA; Dr. Richard E. Flood of Weirton, one of West Virginia's two AMA Delegates; Mrs. D. E. Greeneltch, formerly of Wheeling but now of Sun City, Arizona; Dr. Harry S. Weeks, Jr., Wheeling, also an Alternate Delegate to the AMA, and Dr. D. E. Greeneltch.

WVU Department of Medicine Plans Special Program

A special program on "Current Topics and Advances in Internal Medicine" will be sponsored by the WVU Department of Medicine at the Medical Center in Morgantown on Saturday, March 23.

Dr. Edmund B. Flink, Chairman of the Department, announced that the one-day program will begin at 9:00 A.M. with adjournment scheduled for 4:30 P.M.

Additional information concerning the program will be distributed to physicians in the State prior to the meeting.

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled in the coming months.

1974

Feb. 1-3—AMA Council on Med. Educat. Congress, Chicago.

Feb. 3-6—Am. Hospital Assn., Wash., D. C.

Feb. 10-16—Am. Soc. of Contemp. Ophthal., Miami Beach.

Feb. 10-16—Am. Soc. of Contemp. Med. & Surg., Miami Beach.

Feb. 11-14—Am. Coll. Card., N. Y.

Feb. 13-16—National Assn. Med. Examiners, Dallas.

Feb. 14-16—Soc. Univ. Surgeons, St. Louis.

Feb. 24-28—Med. Soc. State of N. Y., N. Y. City.

Feb. 28-Mar. 2—Ohio Valley Soc. for Plastic & Reconstructive Surgery, Pittsburgh.

Mar. 1-3—Student Am. Med. Assn., Dallas.

Mar. 7-9—Central Surg. Assn., Cincy.

Mar. 15-17—AMA-AMPAC Pub. Affairs Workshop Washington, D. C.

Mar. 20-21—W. Va. Chap. Am. Acad. Pediatrics, Huntington.

Mar. 22-23—Am. Assn. of Ob.-Gyn., Los Angeles.

Mar. 24-25—Am. Soc. Clinical Pharmacology and Therapeutics, Maui, Hawaii (San Francisco, Mar. 28-29).

Mar. 25-28—Am. Coll. Surgeons, Houston.

Mar. 28-29—Am. Bd. Med. Specialties, Chicago.

Mar. 28-30—Am. Assn. for Cancer Research, Philadelphia.

Mar. 29-April 3—Am. Soc. Abdom. Surgeons, Las Vegas.

Mar. 31—April 5—Am. Coll. Physicians, N. Y.

April 1-5—Am. Coll. of Rad., New Orleans.

April 5-7—W. Va. Chapter, AAFP, Charleston.

April 7-12—Am. Assn. Immunologists, Atlantic City.

April 8-11—S.E. Surgical Congress, Atlanta.

April 17-19—Maryland Medical, Baltimore.

April 17-20—W. Va. Acad. of Ophth. and Otol., White Sulphur Springs.

April 20-25—Am. Assn. of Neur. Surg., St. Louis.

April 22-24—Am. Assn. Thoracic Surgery, Las Vegas.

April 22-25—Am. Acad. Pediatrics, Bal Harbour, Fla.

April 22-27—Am. Acad. of Neur., San Francisco.

April 29-May 2—Am. Coll. Ob.—Gyn., Las Vegas.

May 1-3—Am. Surg. Assn., Colorado Springs.

May 1-4—W. Va. Chapter, ACS, White Sulphur Springs.

May 12-15—Am. Thoracic Soc., Cincy.

May 12-15—S. Carolina Med. Assn., Myrtle Beach.

May 12-15—Ohio State Med. Assn., Cleveland.

May 12-16—Am. Assn. Plastic Surgeons, Seattle.

May 16-18—Childhood Cancer, Dallas.

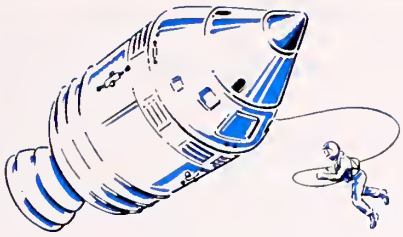
May 17-18—Am. Assn. Clin. Urologists, St. Louis.

May 19-22—Am. Ophthal. Soc., Hot Springs, Va.

June 23-27—AMA, Chicago.

Aug. 21-24—107th Annual Meeting, W. Va. State Medical Assn., White Sulphur Springs.

Sept. 4-7—Am. Assn. Ob.-Gyn., Hot Springs, Va.



Man in space, now fait accompli, re-emphasizes the importance of Uro-Phosphate therapy. Research into the effect of space travel on the astronaut reveals that weightlessness causes loss of bone calcium. As the bones are required to bear less and less of the weight of the body they lose calcium, increasing the calcium content of the urine. When physical activity is reduced, the acidity of the urine should be adjusted to keep increased calcium in solution . . . . a prophylaxis to prevent kidney or bladder calculi.

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WVU Medical Center
–News–

• **Compiled from material furnished by Mrs. Mary Ellin Wylie, Director, Medical Center News and Information Services, Morgantown, W. Va.**

THE training program for family physicians at the West Virginia University Medical Center has been approved by the Residency Review Board of Family Practice and is now accepting applications from prospective residents.

Dr. Clark K. Sleeth said he had been notified of the approval by Dr. Leland Blanchard, Secretary of the Residency Review Board. Doctor Sleeth is now receiving applications at Room 4099, Basic Sciences Building.

Four residents will be accepted into the program which will begin July 1. At the completion of the three-year post M. D. residency training period, the young physicians will be eligible for examination and certification by the American Board of Family Practice.

The establishment of the new program brings to 16 the number of specialty residencies offered at WVU.

Family practice residents will receive rotation training in internal medicine, pediatrics, surgery, obstetrics, psychiatry and other specialties. The program will stress health maintenance and care of the sick in the family unit through its individual members, principally on an outpatient basis. It will also be concerned with evaluation of methods of health delivery and with continuing education for family physicians.

A Family Practice Center to be located on the fourth floor of University Hospital will provide training experiences for the residents. Unlike most clinics at the Medical Center, this facility will provide primary care and will not require referral. Patients will be seen by appointment, and the center will accept responsibility for their continuing care. Families accepted as patients will be representative of the regional population.

The residency program and the center will be headed by Dr. John W. Traubert, Professor and Chairman of Family Practice, WVU School of Medicine. Doctor Traubert is now closing his practice at Wellsburg and Wheeling Hospital and will be in Morgantown about April 1.

Doctor Sleeth is continuing to serve as Acting Chairman until Doctor Traubert joins the staff. Dr. Roland J. Weisser is also a full-time member of the department. A number of part-time members are being added from among family practitioners of the area.

AHEC Funding Continued

West Virginia University has been awarded $398,091 by the Department of Health, Education and Welfare to continue its Area Health Education Center (AHEC) program.

The award is for the program's second funding period, Sept. 30, 1973 to June 30, 1974.

For the initial period beginning Sept. 30, 1972, WVU received $475,086 of which $269,603 in unexpended funds was carried over into the second period.

Dr. Charles E. Andrews, WVU Provost for Health Sciences, is the project director.

West Virginia's AHEC links Charleston Area Medical Center with WVU Medical Center. The plan is to train more physicians in the hope that with clinical clerkships, house staff affiliations and better learning environment in the communities more will be attracted to serve in areas where there are serious shortages of health care personnel.

The AHEC program was launched in September 1972 with the awarding of contracts to 11 medical schools including WVU's. Nucleus of an AHEC is usually a community hospital or consortium of hospitals located at some distance from the medical school.

Pictured above are the new members of the Executive Committee of the West Virginia University School of Medicine's Alumni Association. Their election came during the school's annual Alumni Weekend in October. Seated, left to right, are Drs. Alfred D. Ghaphery of Wheeling, Vice President; Pat A. Tuckwiller, Charleston, President; and Phillip B. Mathias of Morgantown, Chairman. Standing, left to right, are Drs. Clark K. Sleeth, Morgantown, Secretary-Treasurer; Thomas O. Dotson, White Sulphur Springs, and James E. Wilkerson, Tallmadge, Ohio. Also a member of the committee is Dr. J. L. Mangus, Charleston.

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CHARLES S. FLYNN, M. D.
FREDERICK T. EDMUNDS, M. D.
M. S. HAJJAR, M. D
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Maxillo-facial Surgery
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John A. B. Holt, M.D.
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Audiometry

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Nancy McClung, M.S.

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Catherine Kenney, CRNA
Inez Maggio, CRNA
Muriel Dodds, CRNA

The Month in Washington

LITTLE noticed amid congressional confusion in attempting to deal with the energy crisis was the passage of a major health bill shortly before adjournment. The bill provides $375 million over five years to support the development of Health Maintenance Organizations (HMO's) across the country.

The HMO legislation will go far in determining both consumer and provider acceptance of pre-paid group health care. Despite a substantial flow of federal dollars into the experimental program, HMO's are not expected to encounter easy sailing. Ardent supporters of the program admit the trial period will be a rough one and caution against over optimism.

Two key provisions of the $805 million bill first approved by the Senate earlier this year were deleted or watered-down in conference enough to make the measure more palatable to the administration. One would have authorized federal subsidization of HMO premium costs for people who couldn't afford all or part of the cost. The other controversial Senate section would have created an independent Commission on Quality Health Care Assurance to supervise the HMO program. The compromise bill vests this responsibility with the Assistant Secretary of HEW for Health.

To qualify for federal aid, HMO's must meet a long list of federal standards of minimum benefits, stay open 24 hours a day, provide open enrollment, and conform to numerous other requirements. Inducements are provided to attract people from poor and rural areas.

The Senate provision authorizing grants to assist HMO's in meeting operating deficits during the initial three years of operation was knocked out of the final bill, but a loan fund was retained to aid HMO's in meeting "a portion of initial operating costs in excess of gross revenues."

Co-payments were barred under the Senate bill. However, the conference agreed to allow HMO's to charge nominal co-payments, but not to the extent they could be considered a barrier to seeking treatment. The conference committee said the co-payments are aimed at enabling an HMO "to market its benefit package at a competitive price."

The final bill requires larger employers to offer workers an HMO option when existing contracts for health insurance expire provided that a qualified HMO is operating in the area.

The bill does not provide a specific number of HMO's, but the bill's legislative history indicates the Congress had in mind around 100 programs.

• **From the Washington Office of the American Medical Association.**

Legislation to Repeal PSRO

Rep. John Rarick (D., La.), principal congressional sponsor of legislation to repeal the Professional Standards Review Organization (PSRO) program, has dispatched a letter to all members of the House urging their support.

In his letter, Rarick said PSRO "is the hottest controversy facing medical doctors and their patients. The American Medical Association's prestigious House of Delegates voted to seek congressional repeal of this controversial peer-review law that goes into effect on 1 January 1974."

Rarick quoted AMA President-elect Malcolm C. Tood, M. D., as calling PSRO ". . . The greatest threat to the private practice of medicine of any piece of legislation ever passed by congress."

The PSRO section of Medicare was added by the Senate and was never adequately debated, the lawmaker said. "The House did not even hold public hearings on this issue."

Fuel Priorities in the Health Field

The Administration has moved to set clear fuel priorities in the health field as Congress was warned by health leaders that emergency care, drugs and devices and hospital care could be severely affected unless sufficient fuel is made available this winter.

Immediately following a hastily scheduled one-day hearing before the Senate Health Subcommittee, William E. Simon, head of the Federal Energy Office, said the pharmaceutical industry will get all the fuel it needs for production and research in order to maintain adequate supplies of essential drugs and medical supplies.

A spokesman for the American Medical Association testified there is a critical need to make special provisions for an adequate supply of motor fuel to meet the needs of medicine. J. Cuthbert Owens, M. D., a member of the AMA's Commission on Emergency Medical Services, said, "Physicians, nurses, life support personnel, rescue workers, and ambulances and other emergency motor vehicles must have a sufficient and continuous supply of gasoline to insure the provision of prompt care for the ill and injured. In addition, adequate fuel must be available to health care institutions, as well as to suppliers of necessary medical equipment and supplies."

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Obituaries

WILLIAM T. GOCKE, M. D.

Dr. William T. Gocke, a retired surgeon formerly of Clarksburg, died on December 31 in Miami, Florida. He was 84. A native of Tunnelton (Preston County), Doctor Gocke was a graduate of Rock Hill College and received his M. D. degree in 1907 from the University of Maryland.

Doctor Gocke was an honorary member of the Harrison County Medical Society, the West Virginia State Medical Association and the American Medical Association. He was President of the county society in 1934 and a member of the Council of the State Medical Association from 1933 to 1936.

Surviving are the widow; one son, Dr. Jack T. Gocke, Bridgeport; one daughter, Mrs. Donald H. Lough, Clarksburg; and one sister, Mrs. Richard T. Sanner, Stillwater, Pennsylvania.

Funeral services and burial were in Clarksburg.

* * * *

WILLIAM H. PRICE, M.D.

Dr. William (Will) H. Price of Williamson, whose medical career spanned more than half a century, died December 13 in a Huntington nursing home. He was 94.

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A native of Montvale, Virginia, Doctor Price was a graduate of Montvale Sub-Collegiate School and obtained his medical degree from the University of Virginia in 1901. He did postgraduate work on several occasions between 1908 and 1925 at the New York Polyclinic Hospital.

Doctor Price practiced at Chattaroy, in Mingo County, for 42 years beginning in July, 1909. He moved to Williamson in 1951. Prior to moving to Chattaroy, Doctor Price was in practice in Caperton, Eckman and Big Creek, West Virginia, and Georgel, Virginia.

He was a member of the Mingo County Medical Society, the West Virginia State Medical Association and the American Medical Association; and for many years was active in Mingo County civic and fraternal organizations.

Doctor Price is survived by his widow and four daughters, Mrs. Thomas Scharf of Adelphia, Maryland; Mrs. D. E. Tulley of Hollywood, Florida; Mrs. J. A. Warmker of Oklahoma City, Oklahoma, and Mrs. George T. Pinson of Williamson's Fairview Addition.

* * * *

JOHN J. SHERMAN, M.D.

Dr. John J. Sherman, a surgeon who practiced in Huntington for several years after World War II, died December 6 in a Martin, Kentucky, hospital. He was 59.

A native of Ironton, Ohio, Doctor Sherman had

(Continued on page xix)

Radiology:
Karl J. Myers, M. D.

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J. W. Woodford, M. D.

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B. G. Thimmappa, M. D.
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OBITUARIES—(Continued)

degrees from Marshall University, West Virginia University and Rush Medical College in Chicago. He was a U.S. Navy medical officer from July, 1941, until February, 1946.

Doctor Sherman was a former member of the Cabell County Medical Society and the West Virginia State Medical Association. He is survived by his widow; a daughter, Mrs. Richard Carr, Sunnyvale, California; a son, William J. Sherman of San Diego, California, and three sisters.

* * * * *

HERSCHEL R. YOST, M.D.

Dr. Herschel R. Yost, prominent in Fairmont medical circles for 57 years, died December 7 in a hospital there. He was 82.

A native of Fairview in Marion County, Doctor Yost was the son of a physician, and both of his brothers also were doctors.

He was educated in Fairmont schools and was graduated from Eclectic Medical College in Cincinnati, Ohio in 1915. He interned in a Cincinnati hospital.

Doctor Yost was a World War I veteran, and held membership in the Marion County Medical Society, the West Virginia State Medical Association and the American Medical Association. He had been in semi-retirement for several years after beginning practice in Fairmont in 1916.

Doctor Yost is survived by his widow.

County Societies

CABELL

Dr. Gerald Bodey was the guest speaker at the meeting of the Cabell County Medical Society on January 10 in Huntington. His talk was on "Gram Negative Septicemia."

Dr. Thomas F. Scott, President, was praised for his work in primary physician recruitment by Dr. Edwin J. Humphrey, III and was presented with a properly engraved gavel to commemorate his year as President.

Doctor Humphrey announced that the U. S. Department of Health, Education and Welfare has proposed that West Virginia be designated as a single PSRO area.

Dr. William S. Sheils was elected to serve as a member of the Board of Trustees for Cabell-Huntington Hospital. Dr. Gilbert A. Ratcliff, Jr. was elected to serve as a member of the Society's Board of Censors and Doctor Scott was elected a member of the Board of Grievance and Deportment Committee.—Charles H. McKown, Jr., M. D., Secretary.

(Continued on page xx)

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Thoracic Surgery:
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Michael McNeer, M. D.
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David H. Smith, M. D.
Robert L. Mendelson, Ed D.

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J. N. Aceto, M. D.

Speech Pathologist and Audiologist:
James P. Frum, M. S.

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Donna Burlenski
Donna Bryan

Technologists:
Electrocardiography:
Betty Maguire, R. N.
Brenda Muklewicz, R. N.
Electroencephalography:
Joann Green, R. N.
Juanita Stone, R. N.
Roentgenology:
Evelyn Forester, R. T.

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Henry L. Castilow, Asst. Mgr.

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Vice President: Mrs. James H. Walker, Charleston
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Recording Secretary: Mrs. Claude S. Lawson, Jr., Fairmont
Corresponding Secretary: Mrs. W. Paul Elkin, Charleston
Parliamentarian: Mrs. Robert G. Janes, Fairmont

HARRISON

The Woman's Auxiliary to the Harrison County Medical Society met on January 3 at the Stonewall Jackson Hotel in Clarksburg. Mrs. M. V. Kalaycioglu, a member of the Auxiliary, led members and their guests in oriental dances and exercises.—Mrs. Richard F. Fiester, Publicity Chairman.

COUNTY SOCIETIES—(Continued)

HARRISON

Forty members attended the regular monthly meeting of the Harrison County Medical Society which was held at the Stonewall Jackson Hotel in Clarksburg on December 6.

Dr. Min-Choong Chin was elected to membership in the Society and the members also voted to approve the Golden Age Clinic in high blood pressure detection efforts.—Ray A. Harron, M.D., Secretary.

* * * * *

MERCER

The Mercer County Medical Society held its Christmas banquet for members and wives at the Summit House Restaurant December 13. Dr. Hawey Wells of Princeton was installed as the Society's President during the brief program.—John J. Mahood, M.D., Secretary.

* * * *

MONONGALIA

New officers for 1974 were elected at the meeting of the Monongalia County Medical Society on December 4, 1973 at the Old Mill Club in Morgantown. They are Drs. W. Gene Klingberg, President; Herbert E. Warden, President Elect; Robert J. Nottingham, Vice-President; H. Summers Harrison, Secretary, and Hubert A. Shaffer, Treasurer, all of Morgantown.

The Society approved sponsorship of a member as a representative to the American Medical Association National Leadership Conference January 25-27 in Chicago.—H. Summers Harrison, M. D., Secretary.

ACS Trauma Committee Schedules Seminar in Florida

Approximately 150 doctors are expected to attend a three-day seminar on "Life-Saving Measures for the Critically Injured," sponsored by the American College of Surgeons' Committee on Trauma and the department of surgery, University of South Florida, Tampa, March 27-30, 1974.

The seminar is designed particularly for rural and general practitioners, physicians called upon most frequently to render primary medical care to the injured. Though aimed at the non-specialist and emergency department physician, the broad curriculum is also useful to surgical specialists and internists. This three-day course at the Holiday Inn Downtown, is one of 16 being held throughout the U. S. during 1973-74, by the Trauma Committee in cooperation with departments of surgery.

Dr. Roger T. Sherman, chairman of the department of surgery, Tampa General Hospital, Tampa, and professor of surgery, University of South Florida College of Medicine, Tampa, is course director. Doctor Sherman is also a member of the ACS Committee on Trauma.

A faculty of 17 experts in the field of trauma, serving as "teachers," will report on the latest in care of the injured. Four out-of-town speakers included in the faculty are Drs. Curtis P. Artz, Professor and Chairman of the Department of Surgery, Medical College of South Carolina, Charleston; Francis C. Nance, Associate Professor of Surgery, Louisiana State School of Medicine, New Orleans; James W. Pate, Professor and Chairman of the Section of Thoracic and Cardiovascular Surgery, University of Tennessee College of Medicine, Memphis; and James L. Talbert, Professor of Surgery and Pediatrics and Chief of the Division of Pediatric Surgery, University of Florida College of Medicine, Gainesville.

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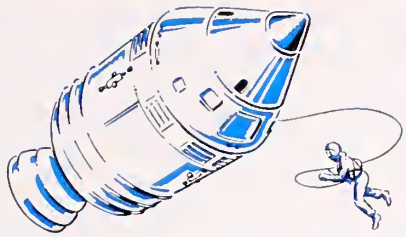

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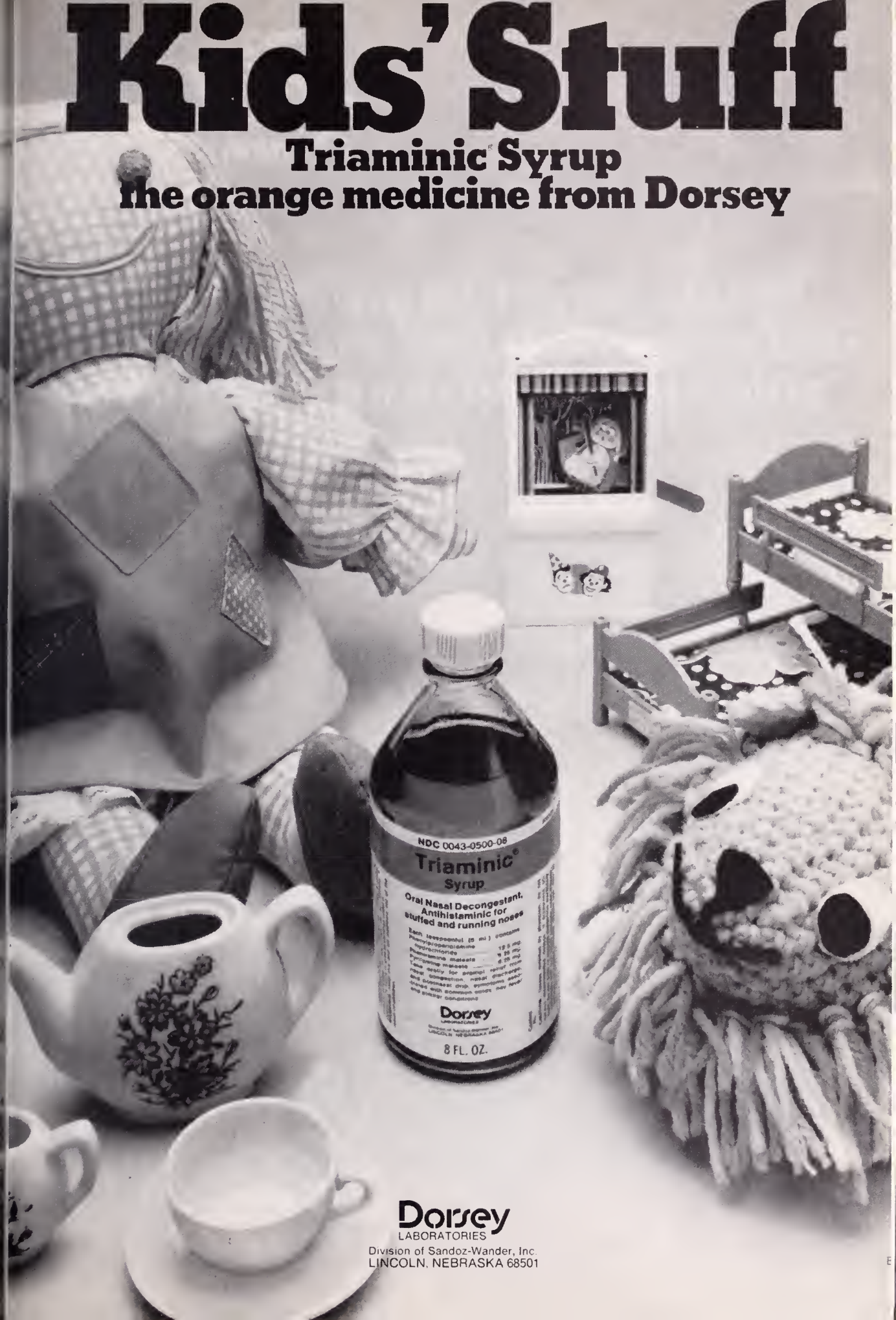

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The Weight of Professional Opinion

It's time for action to defend the laws and regulations that protect your patients against drug substitution.

These professional and trade organizations are united in supporting antisubstitution statutes and regulations:

The American Academy of Dermatology

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Joint Statement on Antisubstitution Laws and Regulations

The purpose of this statement is to affirm the support of the participating organizations for the laws, regulations and professional traditions which prohibit the unauthorized substitution of drug products.

Traditionally, physicians, dentists and pharmacists have worked cooperatively to serve the best interests of patients. Productive cooperation has been achieved through mutual respect as well as a common concern for the ideals of public service. This mutual respect has been reflected, in part, by joint support over the years for the adoption and enforcement of laws and regulations specifically prohibiting unauthorized substitution and encouraging joint discussion and selection of the source of supply of drug products. The basic principles of medical, dental and pharmacy practice are thus utilized and preserved in the interest of patient welfare.

The antisubstitution laws have not obstructed enhancement of the professional status of pharmacy any more than they have in and of themselves guaranteed absolute protection from unsafe drugs, or freed physicians, dentists and pharmacists from their responsibilities to patients. As a practical matter, however, such laws and regulations encourage interprofessional communications regarding drug product selection and assure each profession the opportunity to exercise fully its expertise in drug usage, to the advantage of patients.

Physicians and dentists should be urged to increase the frequency and regularity of their contacts with pharmacists in selection of quality drug products, recognizing that economies to patients can be improved through such communication, taking into account the patients' needs. The pharmacist's knowledge of the chemical characteristics of drugs, their mode of action, toxic properties and other characteristics that assist in making drug selection decisions should be utilized to the fullest extent practicable by physicians and dentists in serving their patients.

Since drug product selection entails knowledge derived from clinical experience, the physician's and dentist's roles in product selection remain primary and do not permit delegation of decisions requiring medical and dental judgments. A broader role in therapy will evolve for pharmacists as improved understanding and cooperation among the professions continue to grow.

There has been no evidence that there are convincing reasons to modify or repeal existing laws and regulations prohibiting the unauthorized substitution of another drug product for the one specified by a prescriber. It is our belief that such laws and regulations merit the joint support of the medical, dental and pharmaceutical professions and the pharmaceutical industry.

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The West Virginia Medical Journal

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Brain Tumors Presenting With Psychiatric Symptomatology

(A Five-Year Survey)

David J. Withersty, M. D.

While intracranial masses can present with changes in behavioral and emotional patterns, the incidence is low and the factor necessary for making such a diagnosis—a high index of suspicion—may be absent.

A recent admission on the In-Patient Service of the Department of Behavioral Medicine and Psychiatry brought this fact to our awareness and prompted the following review of admissions during the past five years as well as a review of the literature. It is hoped that this article will serve to increase the physician's awareness of this diagnostic possibility as this most recent case did for us.

The In-Patient Department of the West Virginia University Medical Center Department of Behavioral Medicine and Psychiatry is a 32-bed unit which serves as a referral resource for physicians and mental health agencies throughout West Virginia, as well as to a lesser extent the surrounding states. One of its purposes is the training of physicians as well as other medical and mental health professionals.[1] As for service, all patients who are referred to the In-Patient Service are evaluated both medically and psychologically. During the period from July 1, 1968 through June 30, 1973, 3,608 patients were admitted to the unit. Within that period four patients were found to have intracranial tumors as the etiology of their symptomatology.

Case Summaries

Case 1.—A 44-year-old white married female, one year prior to admission on the Behavioral Medicine In-Patient Service, was evaluated for headaches and nausea as well as a pressure sensation in the right ear. Evaluation at that time revealed only a mild sensory hearing loss. She was seen again one year later in the Behavioral Medicine Out-Patient Department and evaluated for headaches, nausea and dizziness. Again, evaluation was negative and she was continued in marital counseling. Three months following her visit to the clinic she was admitted to the In-Patient Service for evaluation of "depression." Her family stated that four days prior to her admission she had become very loud and vocal, using abusive language. She would alternate between episodes of crying and extreme elation. Upon admission to the In-Patient Service she was extremely loud and hostile. She admitted to auditory and visual hallucinations and her speech was rambling and tangential. Her emotions were extremely labile, proverb interpretation was concrete, but memory appeared to be intact. She was oriented to time, person and place, and was felt to be undergoing an acute psychotic episode. Organicity was to be ruled out.

Physical examination at the time of admission was extremely difficult due to the uncooperative nature of the patient. Treatment was started with intramuscular thiothixene. The second day of admission she became somewhat more cooperative and by the third day she was somewhat with-

The Author

- **David J. Withersty, M. D., Director of the In-Patient Program and Assistant Professor, Department of Behavioral Medicine and Psychiatry, West Virginia University School of Medicine, Morgantown.**

drawn although still hostile. She began to complain of weakness in the legs. Her speech at that time would alternate between periods of relevance and irrelevancy. As she was more cooperative on the third day a more extensive physical examination was obtained. There were no neurological focal signs present. Papilledema was not noticed and while the pupils were sluggish they reacted to light and accommodation. Cranial nerves II through XII were intact. Strength was symmetrical and the only positive finding was a tendency to fall backwards. Skull films were interpreted as within normal limits and EEG revealed a slow, diffused, nonfocal tracing. Brain scan was positive in that it revealed an increased uptake over the area of the posterior third ventricle. Neurosurgical consult was obtained and the patient was tranferred to that service. Arteriograms indicated a mass lesion as well as internal hydrocephalus. Diagnosis was probable glioma and surgery was felt not to be indicated. The patient was treated with radiation therapy. Initial follow-up seemed to indicate some improvement.

Case 2.—A 23-year-old white married male was admitted to another service of the West Virginia University Hospital for evaluation of "black-out spells" which two weeks prior to admission had resulted in a minor auto accident. He complained of increasing "nervousness for some time" prior to admission as well as bilateral weakness below the knees

Physical examination was within normal limits. Mental status examination was also within normal limits, with the exception of concrete proverb interpretation and poor recent memory. Impression was post-trauma amnesia with seizure disorder to be ruled out. EEG revealed only a single burst of 14 positive spikes and was not felt to be meaningful. He became agitated and was transferred to the Behavioral Medicine Service where he was diagnosed as manic depressive disorder, manic type and treated with chlorpromazine. He was discharged about two weeks later slightly improved.

One month later he was again admitted to the Behavioral Medicine and Psychiatry In-Patient Service. He had become more hostile and agitated and had had frequent temper outbursts. Affect was labile and he had become enuretic several days prior to admission. Again physical examination was within normal limits and review of systems was negative for a history of headaches. There was little change in mental status—he was concrete on proverb interpretation and affect was labile but he was oriented. Diagnosis was to rule out psychotic O.B.S. and rule out manic phase of manic depressive disorder.

A neurology consult was obtained and a questionable Babinski was elicited. He continued to complain of weakness below both knees. A brain scan was obtained which revealed a midline, suprasellar mass and neurosurgery was consulted. A right frontal craniotomy was performed and the final diagnosis was craniopharyngioma. The postoperative course was complicated by development of diabetes insipidus and a seizure disorder. He was treated and finally discharged for supportive nursing care.

Case 3.—A 69-year-old white married male was admitted to the Behavioral Medicine In-Patient Service with a history of periods of confusion six weeks prior to admission. He aggravated his family by constantly running water in the bathtub. He was noted to be acting "intoxicated" on occasion and had become hostile toward an employee in a store. He had complained of headaches "several weeks" prior to admission and the family had noted that he had what appeared to be difficulty in raising his right hand.

Physical examination was difficult as the patient was uncooperative, but neurological examination appeared to be within normal limits with the exception of a questionable "dragging of the left foot". Blood pressure was 112/74. Mental status revealed a disheveled male who was uncooperative and used abusive language. He was oriented. Recent memory was poor. Impression at that time was possible organic brain syndrome, probably CVA. Brain scan was obtained and revealed a large parasaggital mass lesion. EEG was interpreted as Grade II dysrhythmia with a focal abnormality of the right frontotemporal region. Neurosurgery performed a right frontal craniotomy with right frontal lobectomy and the postoperative diagnosis was right frontal glioblastoma multiforme (astrocytoma Grade IV). As residual tumor existed, he was further treated with radiation therapy and finally transferred to a nursing home for supportive nursing care.

Case 4.—A 55-year-old white married female was admitted to Behavioral Medicine and Psychiatry for evaluation of "severe depression." Two years prior to admission she complained of headaches and "dizzy spells."

She had lost much of her equilibrium and needed support in walking. The headaches had been increasing in frequency. Two months before admission her husband had retired and she admitted to becoming severely depressed while futilely attempting to "keep up with him." She denied suicidal ruminations. Initial pertinent find-

ings included a right facial palsy, left ptosis and poor coordination. Mental status revealed an uncooperative female who was lethargic and listless. Speech was slurred. Thought content was appropriate. Neurology consult was obtained and a brain scan revealed a large right frontal lobe tumor. Neurosurgery performed right frontal lobe trephination and a needle biopsy revealed reticulum cell sarcoma. She was treated with radiation therapy. At the time of discharge she was unable to ambulate by herself but had improved both subjectively and objectively with normal affect.

Discussion

Most studies of patients with intracranial tumors that present with psychiatric symptoms have been conducted on long-term, chronic care units.[2,3] Under these conditions incidence rates vary from two to three per cent. The study conducted on a short term, acute care psychiatric unit which is most often quoted in the literature is that of Remington and Rubert (1961).[4] They reviewed the charts of all patients admitted to the Syracuse Psychiatric Hospital over a 30-year period who were diagnosed as having "psychosis due to brain tumor." There were 34 patients included in this category for a frequency of two-tenths per cent. Ten of the 34 cases were known to have brain tumors on admission. The others were diagnosed as functional problems and the diagnostic impressions included depression (eight cases), memory deficits (seven cases), combative behavior (five cases), personality "change" (two cases), paranoid ideas (two cases), marked agitation (two cases) and severe obsessional ideas (one case). All of their "undiagnosed" cases were found to have a brain tumor during hospitalization only after sensorimotor symptoms appeared. If the ten known cases of brain tumor are eliminated from these statistics, the incidence of "undiagnosed" cases becomes .14 per cent.

Of the four cases that we have noted during the past five years on our In-Patient Service, three presented with complaints of headaches. Sensorimotor deficits or questionable sensorimotor signs were noted in all four cases. One patient complained of leg weakness shortly after hospitalization while in the process of being evaluated for organicity, but all four complained either of bilateral leg weakness or had difficulty in walking. All had positive histories of personality changes prior to admission.

Initial working diagnosis in these cases included acute psychotic reaction (one case), manic depressive disorder, manic type (one case), CVA (one case), and a severe depression (one case). All patients were evaluated for organicity and all four had positive brain scans.

Summary

In summary, our five-year review of the incidence of patients with brain tumors who presented with psychiatric symptomatology (.11 per cent) is compatible with previous reviews conducted on a short term, acute care psychiatric unit. It is hoped that our review will increase the physician's index of suspicion to the possibility of brain tumor in the case of any patient who presents with headaches and sudden unexplained behavioral changes which may range anywhere from temper outbursts and difficulty in relating to family members, to neurotic symptoms of anxiety or depression or even psychotic states. There exists no typical clinical picture.

A list of references may be obtained by writing The Journal.

Assessing Extent of Dead Heart Tissue

A way of assessing the extent of dead heart tissue resulting from a heart attack has been described by University of Chicago investigators. Dr. Paul V. Harper, Professor of Surgery and Radiology, said the method involves injecting radioactive ammonia into a vein. The ammonia seeks out the undamaged part of the heart, and radiation is detected outside the body with a nuclear camera, which outlines the damaged portion. Extent of damage is a factor in determining whether surgery is necessary.

The Assessment Of Myocardial Infarction With Serum Enzyme Determinations*

William E. Shell, M. D.

ELEVATED serum enzyme activity has become a cornerstone in the diagnosis of acute myocardial infarction. The absence of elevations when carefully sought for is an excellent criterion for exclusion of the diagnosis. Recently, investigative effort regarding serum enzyme elevations in patients with acute myocardial infarction has been directed toward the use of such determinations as indices of prognosis and specifically as a means by which the extent of ischemic myocardial injury can be quantified. Rapidly accumulating evidence suggests that prognosis after acute myocardial infarction is related to the extent of myocardial necrosis and that this in turn is reflected quantitatively by the magnitude of alterations of serum enzyme activities.

In experimental studies in the 1950's it became clear that a general relationship existed between peak serum enzyme activity following coronary occlusion and the extent of myocardial necrosis assessed morphologically. Experimental myocardial infarction produced in open chest or closed chest preparations consistently led to elevated serum enzyme activity in serum. In general small infarcts were associated with low peak levels of SGOT and LDH and large infarcts were associated in high peak levels. However, peak levels of these and other enzymes exhibited considerable variation in animals with infarcts of comparable size; hence, in individual animals determination of peak enzyme activity does not permit reliable estimation of infarct size measured pathologically. This variation is due in part to the effects of surgical interventions utilized in producing the experimental infarction on the activity of serum enzymes, biological variation in the rate of enzyme release from ischemic myocardium, and nonuniform ischemic injury within the infarct itself.

Despite these limitations, considerable evidence indicates that the magnitude of peak serum enzyme activity following myocardial infarction presages prognosis. After spontaneous myocardial infarction in man SGOT begins to rise—usually within 12 hours—and reaches a peak level within 24-36 hours. Peak SGOT values greater than 300 Karmen units has been associated with adverse prognosis and with a mortality of 40 per cent within the first six weeks. On the basis of autopsy studies it is apparent that a linear relationship exists between gross morphologic estimates of infarct size (small, medium and large) and the magnitude of serum enzyme elevations. Thus, patients dying with small infarcts exhibited an average peak SGOT of 100 K.U. compared to 180 K.U. in those with medium infarcts and 450 K.U. in those with large infarcts. It is likely that hepatic release of SGOT, reflecting congestive heart failure, contributes to the marked elevations seen in patients with large infarcts.

Serum lactic dehydrogenase (LDH) activity bears a similar relationship to infarct size. Peak LDH levels of greater than 150 U/ml. are associated with increased risk and apparently large infarcts. A level of serum alphahydroxybutyric acid dehydrogenase (HBD), reflecting the activity of isoenzymes of LDH typical of those seen in heart muscle, exceeding 800 IU/ml. has been associated with mortality rates of 30 per cent while a level less than 800 IU/ml. has been associated with a mortality rate of 15 per cent or less. It is important to recognize that LDH activity in serum frequently reflects extraneous sources of enzyme, particularly the red cells which release large quantities of LDH into serum with even minimal hemolysis.

Serum creatine phosphokinase (CPK) activity appears to be a good index of prognosis. Peak serum CPK activities exceeding 600 mlU/ml. are associated with mortality rates greater than 30 per cent while values less than 600 mlU/ml. (12 times normal) are associated with a risk of only 12 per cent. It has been found that peak values less than 300 mlU/ml. are associated with mortality rates of only 2 per cent. Results of CPK determinations are dependent upon the specific

The Author

- **William E. Shell, M. D., Department of Medicine, University of California, San Diego Medical School.**

*Provided by the American Heart Association, West Virginia Affiliate.

assay employed and become meaningful only when the assay is performed with careful attention to technique.

Morbidity and Mortality

Morbidity as well as mortality appeared to be related to the magnitude of peak serum enzyme activities following myocardial infarction. Major arrhythmias such as ventricular tachycardia, ventricular fibrillation, and A-V block occur much more commonly in patients with high peak serum enzyme activities. Severe hemodynamic abnormalities also appear to be more common in patients with high enzyme values. Moreover, the hemodynamic abnormalities may persist for several months or indefinitely in those patients with high serum enzyme values associated with an episode of acute infarction. Patients with marked serum enzyme elevations are likely to show increases in left ventricular end diastolic pressure during the acute phase and frequently progression of these abnormalities during succeeding months. Wall motion disorders are also more common in those patients with marked elevation of serum enzyme activity. It appears likely that the eletrophysiological, physiological and prognostic features associated with marked elevation of serum enzyme activity after acute myocardial infarction are all related to infarct size, in turn reflected by the magnitude of peak enzyme elevation.

Peak Level of Enzyme Activity

The peak level of enzyme activity observed after acute myocardial infarction depends on several factors including: (1) frequency of sampling, (2) the rate of enzyme release from myocardium, (3) the rate of enzyme clearance from the circulation, (4) the volume into which the enzyme is distributed, (5) contributions from extraneous non-cardiac sources of enzyme, and (6) infarct size. In order to relate enzyme changes appropriately to infarct size and to prognosis, these factors must be taken into consideration. In patients with acute myocardial infarction samples for enzyme determinations at least every 12 hours are helpful in assessing trends and in determining the actual peak level. Intramuscular injections should be kept to a minimum in order to reduce the likelihood that extraneous sources of enzyme will cloud the picture. Blood samples must be obtained with thorough precautions to avoid hemolysis. Isoenzyme determinations should be employed to facilitate interpretation of elevated enzyme activities.

Since the observed levels of enzyme activity in blood in part reflect infarct size, serum enzyme analysis may offer a more precise means of estimating the extent of myocardial injury associated with a specific episode of infarction. We have recently utilized serial changes in serum CPK activity to measure infarct size in patients. The approach is based on a mathematical model which takes into account the rate of CPK release, CPK clearance and the plasma volume into which CPK is distributed. In animal experiments we have observed a close correlation between infarct size assessed from serum CPK changes analyzed with the use of this model and infarct size measured directly by analysis of myocardial CPK depletion. In patients, assessment of infarct size by serial serum CPK analysis has served as a reliable index of subsequent mortality and morbidity. In patients with estimated infarct size exceeding 50 CPK-gram-equivalents, acute mortality (within 30 days) was 36 per cent compared to three per cent in those patients with infarct size less than 50 CPK-g-eq. Long term mortality and morbidity was similarly related to CPK-infarct size. In patients followed for six to twelve months, 67 per cent of those with infarct size exceeding 65 CPK-g-eq were either dead or Class III or IV. Thus, analysis of serial enzyme changes has proven useful in the assessment of infarct size, in turn a valuable index permitting separation of patients according to risk.

Summary

Peak SGOT, LDH, and CPK levels are related to prognosis after acute myocardial infarction. Peak serum enzyme activity and prognosis correlate probably because they are both related to infarct size. Infarct size can be estimated reliably in patients by mathematical analysis of serial serum CPK changes. This approach permits improved assessment of risk in specific patients with acute myocardial infarction and should prove valuable not only in facilitating the management of individual patients but also in conducting clinical trials to assess therapeutic mortalities with potential risk. Clinical enzymology is no longer merely a tool for the recognition of acute myocardial infarction but is rapidly becoming applicable as an important means for assessing the severity of the infarction and estimating prognosis reliably.

Acquired Arteriovenous Fistula Following Traumatic Amputation Of The Right Arm

(Report Of A Case)

William C. Dressler, M. D.; Mansour Jadalizadeh, M. D.; Gabriel Al-Hajj, M. D.; Catalino B. Mendoza, Jr., M. D.; And Raymond C. Bonnabeau, Jr., M. D.

Arteriovenous fistula (an abnormal communication between the arterial and venous systems resulting in a left to right shunt of varying magnitude) was first described by William Hunter in 1757 and can be acquired, either resulting from blunt (Pratt, 1954) or penetrating injury (Pratt, 1946), or can be congenital in origin.

This paper reports the appearance of an arteriovenous fistula between the right axillary artery and vein in the case of a patient 24 years after traumatic amputation of the proximal right arm.

Case Report

A 50-year-old white male was admitted to the Veterans Administration Hospital with the chief complaint of a throbbing, painful mass in the right axilla that had increased in size over the prior three-month period.

Historically, he had been involved in a mine accident in 1949. Injuries sustained at that time necessitated amputation of both the right arm (at the level of the proximal third of the humerus) and the right leg (above the knee).

Admission physical examination revealed an alert 50-year-old man with blood pressure of 106/60 mg. Hg. There was a warm, five by five cm., tender, palpable mass (with prominent thrill and Grade VI/VI systolic murmur) in the right axilla and stump of the right arm. No dilated collateral vessels were present.

Laboratory studies and electrocardiogram were within normal limits. Although the chest x-ray was considered to be normal, a calcific density was noted in the right axillary area in the region of the tender mass (Figure 1-A). A selective innominate arteriogram was next performed via the transfemoral route, utilizing the Seldinger (1953) technique. Good visualization of a markedly dilated and tortuous axillary artery was obtained. Direct passage of the contrast material (50 per cent Hypaque[R]) from the right axillary artery into the axillary vein confirmed the clinical impression of a functioning arteriovenous fistula at this location (Figure 1-B).

The Authors

- **William C. Dressler, M. D.; Mansour Jadalizadeh, M. D.; Gabriel Al-Hajj, M. D.; Catalino B. Mendoza, Jr., M. D.; and Raymond C. Bonnabeau, Jr., M. D., all from the Departments of Surgery, West Virginia University School of Medicine, Morgantown; and Veterans Administration Hospital, Clarksburg, West Virginia.**

Subsequently, the patient was taken to the operating room where, through a 12-inch transverse incision, the right axilla was explored and the second and third portions of the axillary artery and vein dissected free from surrounding scar tissue. This maneuver exposed the three by four by five cm. mass of communicating vessels. Comparison blood gas determinations obtained at this time from the exposed axillary artery and vein revealed arterialization of the vein as a direct result of the moderate left to right shunt (Table 1).

Division of the pectoralis major and minor muscles made possible ligation and division of the axilliary artery in its second portion. The axillary vein and brachial plexus also were divided and the entire distal mass of fistulous vessels excised. The patient made an uneventful recovery.

Table 1.

Acquired Arteriovenous Fistula Following Traumatic Amputation Of The Right Arm

Blood Gas Determinations During Operation At The Fistulous Site

	Axillary Artery	*Axillary Vein*
pH	7.41	7.43
pO_2 (mm. Hg.)	129	127
pCO_2 (mm. Hg.)	37	37
O_2 Saturation (%)	98	99

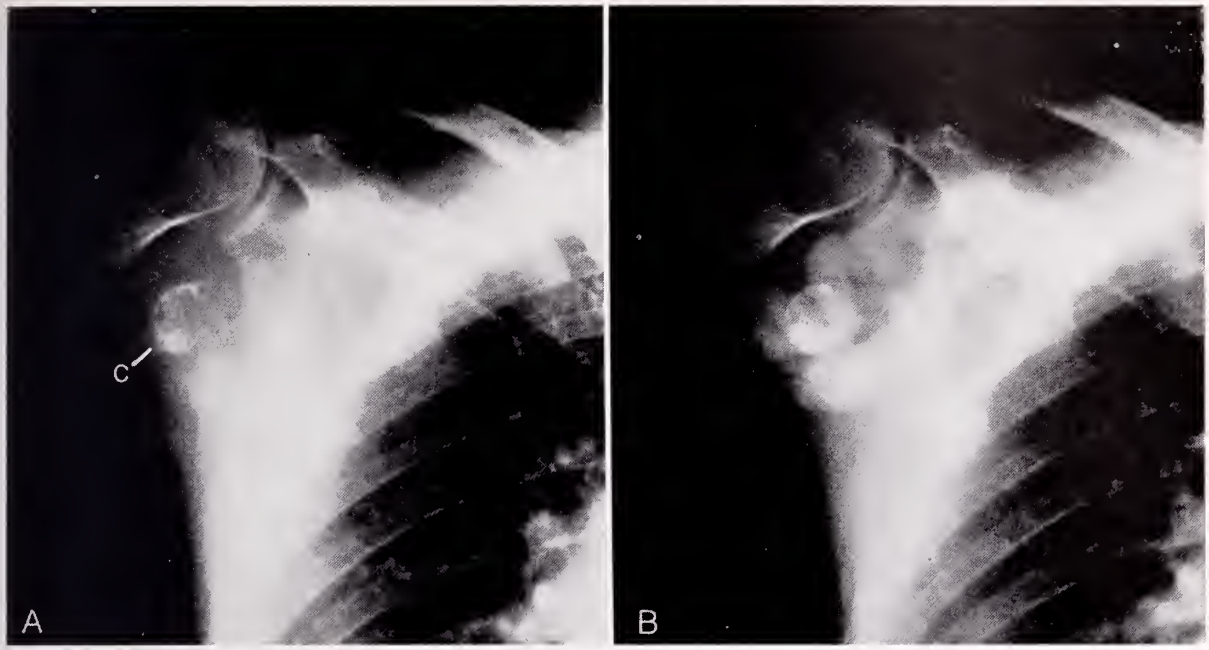

Figure 1-A. AP x-ray of the patient's right shoulder region. The suspeeted arteriovenous fistula was loeated in the axilla where the vascular caleifieation (C) may be seen. Figure 1-B. AP x-ray of the patient's right shoulder region taken during the seleetive innominate arteriogram. Contrast material may be seen simultaneously outlining the large, tortuous, communieating axillary artery and vein. This study eonfirmed the elinieal impression of a funetioning arteriovenous fistula at this loeation.

At the time of discharge, his blood pressure was 120/80 mm. Hg.

Comment

An arteriovenous fistula alters the cardiovascular physiology of the body in many ways; the overall change being related to the magnitude of the left to right shunt. In general, the peripheral vascular resistance tends to become decreased. If the reduction is significant, a low diastolic blood pressure with increased pulse pressure may be apparent. In large shunts, an increased blood volume, as well as increased pulse rate, will be found. Immediate slowing of the latter may at times be noted upon obliteration of the large fistulous communication (Branham's sign). In the presence of a massive shunt, cardiac enlargement with incipient or actual failure can be present.

Diagnostically, thrills, murmurs, enlarged collateral vessels, chronic venous stasis ulcers, cardiomegaly, one limb larger or warmer than the other may be present. One or more of these findings, together with pain associated with an obvious vascular tumor mass, should alert the clinician to the presence of an abnormal arterial-venous communication or communications (de Takats, 1959). Increased skin temperatures with differentials up to 12 degrees Centigrade also have been reported (Pratt, 1954).

The absence of many of these clinical features in the case of the patient described in this report was indicative of only a moderate degree of shunting. Operative obliteration of the communication or excision of the involved vessels is the treatment of choice.

Summary

A case of arteriovenous fistula manifesting itself in a patient 24 years following traumatic amputation of the proximal right arm, with successful treatment by operative excision is reported.

The physiological derangements as well as the diagnostic criteria are briefly presented.

A list of references may be obtained by writing The Journal.

Special Article

The Family Physician*

W. Rhys-Jones, M. B., B. Ch.

THIS talk will be divided into five sections, each one running into the next. The sections are:

(1) The definition of a Family Physician.
(2) His training—past and present.
(3) The qualities he needs.
(4) His function in the scheme of health care at present.
(5) His future place in health care.

To show that the concern about lack of Family Physicians is not a recent one, I shall quote (I was once advised all talks should have a quote) Martial, First Century A.D.—"Cascellius extracts or fills an aching tooth; Hyginus burns away the hairs that hurt the eyes; Fannius relieves, without cutting, the relaxed uvula; Eros effaces the melancholy brand marks of slavery from Freedmen's foreheads; Hermes is a very Podalirius in curing hernia; but tell me Gallus, where is he that can help my harassed person?"

The Ad Hoc Committee on Education for Family Practice of the Council on Medical Education, American Medical Association, 1966, in its report entitled "Meeting The Challenge of Family Practice," came up with the definition that the Family Practitioner is one who:

(1) Serves as the physician of first contact with the patient and provides a means of entry into the health care system.
(2) Evaluates the patient's total health needs, provides personal medical care within one or more fields of medicine, and refers the patient when indicated to appropriate sources of care while preserving the continuity of care.

(It is with the wording in this statement that one is in disagreement: "one or more fields of medicine" to my way of thinking should read "provides personal medical care in many fields of medicine,"—my main contention being that a Family Physician should be able to deal with a family *in toto* and thus be able to cover or have knowledge of all medical subjects from womb to tomb.)

(3) Assumes responsibility for the patient's comprehensive and continuous health care and acts as a leader or coordinator of the team that provides health services.
(4) Accepts responsibility for the patient's total health care within the context of his environment, including the community and the family or comparable social unit.

The Author

- **W. Rhys-Jones, M. B., B. Ch., Family Medicine Centre, University of Ottawa-Ottawa Civic Hospital, Ottawa, Ontario, Canada.**

The report then goes on to say that "The Family Physician is a personal physician oriented to the whole patient, who practices both scientific and humanistic medicine".

In Britain the term, "General Practitioner," is still used in preference to the term, "Family Physician." A Working Party of The Royal College of General Practitioners in 1969, however, came up with the definition that the general practitioner is a doctor who provides personal, primary and continuing medical care to individuals and families. He may attend his patients in their homes, in his consulting room or *sometimes* in hospital (this word "sometimes" crops up due to the fact that the majority of patients admitted to hospitals in Britain are generally directly under the care of a specialist and his team). He accepts the responsibility for making an initial decision on every problem his patient may present to him, consulting with specialists when he thinks it appropriate to do so. He will usually work in a group with other general practitioners, from premises that are built or modified for the purpose, with the help of para-medical colleagues, adequate secretarial staff and all the equipment necessary. Even if he is in single-handed practice he will work in a team and delegate when necessary. His diagnosis will be composed in physical, psychological and social terms. He will intervene educationally, preventively and therapeutically to promote his patient's health.

Finally from the Educational Objectives for Certification in Family Medicine, College of Family Physicians of Canada, March 1971, "A certified Family Physician shall be a physician who is trained to provide primary, continuing

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and comprehensive health care to any and all members of the family using the available ancillary and consultant services to ensure exemplary health care." This brings to mind the candidate at the certification examination who, when faced with the problem of a wife coming to see him for abdominal pain, discovered it was psychogenic and caused by her oft-drinking husband continuously beating her up. When asked what he would do he stated, "I come from a small town in New Brunswick where we don't have any social workers or public health nurses—so, since I would probably know she had two burly brothers, I would phone them up and tell them to go and beat the hell out of their sister's husband." He got his certification.

Whole Family Concept

Amen to definitions. The next question is "What is the difference between a general practitioner and a family physician?" The answer is vague—the old and present rural practitioner is a family physician. Many urban practitioners of long standing are family physicians. Any general practitioner who gets to know, understand and thinks automatically of family is a family physician. The general practitioner who thinks of each person in front of him as "a case" is not.

Are all primary contact physicians entitled to be called family physicians? No. Are all personal physicians entitled to be called family physicians? No. Are general practitioners who limit their practices to certain age groups entitled to be called family physicians? No. Primary contact, personal physicians may be internists, pediatricians, obstetrician/gynecologists, and so on. These along with restricted practice general practitioners deal only with certain sections or age groups and thus, even though carrying out what they fully believe is family practice, are in reality fragmenting health care even further; for example, the pediatrician who refers mother to a gynecologist for vaginitis and father to a cardiologist for his chest pain. One thing that has evolved since the inception of our programs in family medicine in Canada is that many of the above quoted personal or primary contact physicians are now referring more and more people to family physicians—thus making a two-way referral pattern. This is also allowing the specialist to concentrate more on what he has been trained to do.

If I use the words general practitioner or primary contact physician from now on, I will be alluding to the family physician.

Education of the Family Physician

The next stage is the education of a family physician. The basic undergraduate education has been and still is the same both for budding specialists and family physicians. In the "old" days students went through medical school, did their basic sciences and then went through various specialties with the stress being basically on organic medicine. After having successfully passed their final medical examinations they were entitled to be called a Doctor of Medicine (in Britain and Ireland we were called Bachelors of Medicine—this may have been due to our not marrying as students) and then they could go out and wreak their greenness upon the population. Later on students had to do a rotating internship before being allowed to practice. This rotating internship again was specialty and hospital oriented, with the result that a doctor going into practice had no contact with, or knowledge of the community and its illnesses.

To quote figures to support this—out of each 1,000 adults at risk 750 will have one or more illnesses per month, 250 will see a doctor one or more times a month, nine will be admitted to a hospital per month, five will be referred to another physician and one (only one out of the 1,000) will be referred to a university medical center a month, (Quote from White K. et al, "The Ecology of Medical Care", *New England Journal of Medicine* 265: 886-891, 1961).

Family Medicine Programs

Enlightenment came into medical schools eventually and they started looking at mental as well as organic health, and later many medical schools started exposing students to the community and its resources. However, a lot of this latter is lost when doing a hospital oriented rotating internship. Many medical schools are now setting up family medicine programs, and at long last family physicians-to-be are going through a special training to fit them for their future life work. In many programs in Canada this is a two-year residency (the first year being the internship year), depending on the fact that they have already had an adequate exposure to family medicine in their undergraduate training.

It is our belief that a person having gone through our program is on an equivalent base to the family physician of at least five years' standing in practice after doing only a rotating internship. It is also felt that at long last the family physician is gaining his rightful prestige and that his knowledge and use of the multitude of skills that he has is finally being recognized. No longer is he regarded as a "drop out" or "a

specialist who didn't quite make it." Many physicians who went into general practice in the past did so because they wanted to. They had the latent skills required but unfortunately had to develop them by means of trial and error. In the foreword to a book produced by the Royal College of General Practitioners in 1972 entitled, "The Future General Practitioner, Learning and Teaching," they state that "The doctor leaving the medical school and looking for his future role is no longer a general doctor qualified to start as a principal, but a *basic* doctor, grounded in the sciences that contribute to medicine and in clinical method. He lacks the training and experience which we now recognize as necessary before he can be permitted to care, unsupervised, for patients in a general practice.'

Certain Skills Essential

A family physician needs to develop certain skills just as a trainee in any other specialty has to. Besides being able to manage symptomatic disease, a family physician must learn how to take care of patients in the family and community setting, with emphasis on health maintenance, preventive medicine and comprehensive care; to do family and marital counselling; to manage common emotional problems; to stabilize the family and prevent further illness or breakdown in times of illness, death or chronic disabling disease of a member of the family (whether they all be patients of his or not); to work in closer relationship to an expanding health team, social workers, community health nurses, medical consultants, physiotherapists, and to develop an increasing awareness and proper utilization of the diverse community resources available such as voluntary health agencies, counselling agencies and the clergy.

John Geyman, in his book "The Modern Family Doctor and Changing Medical Practice," has a chapter on the requisites for the family doctor. I feel that these should be the requisites for any physician in any field of medicine. These are an interest in people, good judgment, broad interests, decisiveness, assumption of responsibility, stability, a good sensitivity-objectivity mix, to be a thinker-doer, to have flexibility, to be at ease with interpersonal relationships, the ability to develop a comprehensive approach to people and problems, to have stamina, the ability to pace oneself, a basic attitude of optimism, tact, self-confidence, the enjoyment of learning new clinical knowledge and developing new skills (these latter two can be carried out by face to face consultations between specialists and family physieians in the hospitals and by attending meetings, workshops, or doing postgraduate work in various specialty services). In Canada to maintain membership or certification in The College of Family Physicians, one has to show proof of having done at least 50 hours per year at approved postgraduate courses and meetings.

In the United States, in 1900, there was one general practitioner for every 600 people; in 1971 one for every 3,000. Again, in the United States, in 1931, there were 112,000 general practitioners; in 1970 there were 55,341. In 1940, eight out of 10 graduates from American medical schools entered general practice; in 1965, nine out of 10 entered the specialties. The figures for the earlier years cannot truly be accepted as genuine as specialties started to be recognized only in 1917. The first was for ophthalmology; the next specialty recognized was Obstetrics/Gynecology in 1930, and the latest being family medicine in the 1960s. While looking at the dates of setting up specialty boards, it was interesting to note that orthopedics, colon-rectal surgery, urology and plastic surgery were recognized before general surgery. In 1919, a resolution was brought before the AMA requesting that family medicine be recognized as a distinct specialty and it was rejected. Fifty years later it was accepted. In the late fifties—early sixties both in Canada and the United States—the importance of family physicians was starting to be noted by the public and eventually by the medical profession. My hope is that the pendulum does not swing too far towards family medicine to the detriment of specialization, but comes to rest at the correct point of equilibrium.

Today's Role of the Family Physician

Where is the family physician in today's health scene? A lot of people are asking, "Where does one find a family physician?" The family physician is becoming more and more frequently the primary contact physician and people are now looking at him as both their personal and family doctor, that he will look after most of their problems (in the U.K. about 90 per cent, in North America about 95 per cent), and that if he is unable to look after a problem he will refer them to the appropriate consultant and work in harness with the consultant. In Ottawa, more specialists are referring patients to family physicians and doing far less trans-specialist referrals. In hospitals, more patients are being admitted under the family physician. If consultations are needed, the specialist will see the patient and advise the family physician on the course of action. The only time a patient is transferred to the care of the specialist is if his expertise is needed for acute care over a period of time.

Even then he expects the family physician to look after any other needs in unrelated fields, if necessary.

The Future of the Family Physician

What of the future? Not only will the family physician do what he is now doing, but he'll have to do more. He will have to work with and develop new expanded roles for allied health personnel. He will need to become a leader of a health team, delegate some of his present work loads to the team and thus use his skill and training to its utmost. He will need to develop a greater interest in research or, as John Fry says, "organized curiosity," not only in medical topics, but in new methods of health care delivery. This latter is important; if not done, governments will do it themselves and may enforce some unpalatable jackass schemes.

Having just mentioned the delegation of authority, I will close with a quote from the *Ontario Medical Review*, June, 1973: "One of life's lessons is that the golf courses, beaches and cruise ships of the world are populated with executives who learned to delegate authority."

A list of articles and textbooks recommended for suggested reading may be obtained by writing The Journal.

Manuscript Information

Manuscripts to be presented for publication in *The West Virginia Medical Journal* should be typewritten, triple-spaced, on one side only of firm (not onion skin or flimsy), standard letter sized (8½ by 11 in.) white paper. Wide margins (at least 1¼ in. on left) should be left free of typing. On the first or title page should be shown the title of the article, the name (or names) of the author, and his degrees. Pages should be numbered consecutively, the page number being shown in the right upper corner along with the surname of the author.

Authors are requested to submit a carbon copy with the original or retain same in the event the manuscript is lost in transmittal.

Illustrations should be numbered and their approximate locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for cuts should be done in black (India) ink on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it. The author will bear the cost of all over two one-column halftone cuts.

All scientific material appearing in *The Journal* is reviewed by the Editorial Board. Manuscripts should be mailed to The Editor, West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

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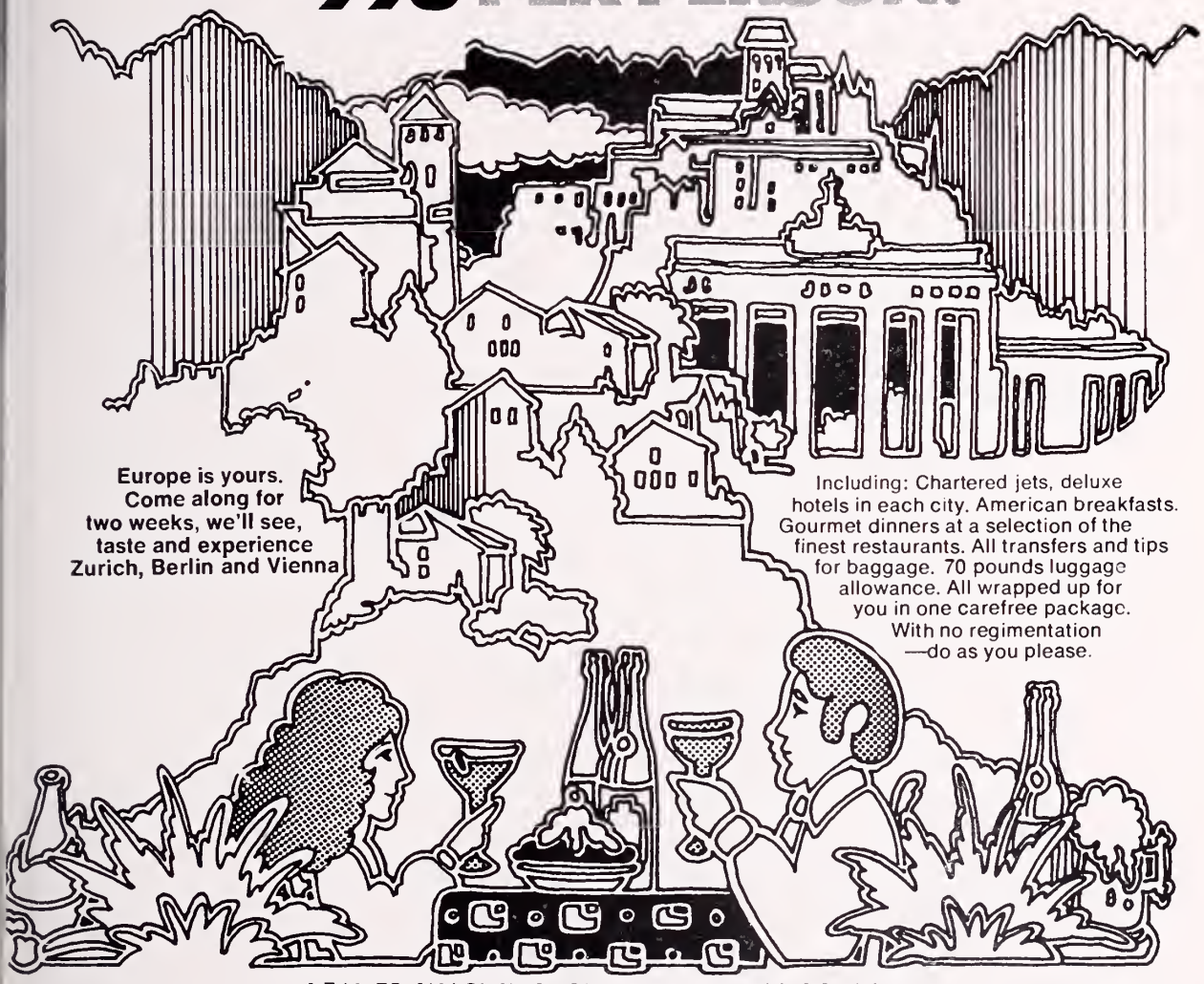

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The President

THE ELEVENTH COMMANDMENT

One sometimes wonders if anyone ever reads this page. I must confess, at the certain risk of offending all the past presidents of this organization—but why shouldn't I offend them, I've offended everybody else—that until I started writing this thing I never read them.

I'm tempted to write a dirty joke just to see if anyone is offended. Or, maybe an ethnic story, always sure to offend the minority involved.

A lady for whom I developed great respect, my wife's late mother—put harshly, my late mother-in-law—had an unusually clear perception of what was really important and added what she called the Eleventh Commandment—"Thou shall not take thyself too seriously."

Or, put another way, just think in 10 more years these will be the good old days.

Tom McCoy

A. Thomas McCoy, M. D., *President*

THE WEST VIRGINIA MEDICAL JOURNAL

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Editor
GEORGE F. EVANS, M. D.
122 South Sixth St.
Clarksburg, W. Va.

Managing Editor and
Business Manager
MR. WILLIAM H. LIVELY
Box 1031
Charleston, W. Va. 25324

Associate Editors:
VERNON E. DUCKWALL, M. D.
Elkins
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Charleston
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Wheeling

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EDITORIALS

REGRESSION OF CARDIAC HYPERTROPHY FOLLOWING HYPOXIA

Regression of cardiac hypertrophy has been discussed editorially previously in *The Journal* (April, 1969 and May, 1971). This present essay deals with some carefully controlled experiments recently published[1] on regression of cardiac hypertrophy following exposure to hypoxia.

It has been known for many years that dwellers of high altitude, such as those in the Andes Mountains in South America, who presumably are in good health, have a larger heart than those who live at lower levels. Both main chambers of the heart are enlarged, but the right ventricle shows proportionally a greater hypertrophy than the left. This is due to the increased pulmonary arterial hypertension found at high altitudes. Enlargement of the heart under these conditions is considered a compensatory physiologic phenomenon. There is proof that if these mountain dwellers move down to significantly lower levels, cardiac hypertrophy will regress, and the heart will return to normal size.

It is not possible to measure exactly the size of the heart with the x-ray in living man; even if this could be done, one could not distinguish between cardiac dilatation and a true enlargement. The most exact means of obtaining the size of the heart is to determine its weight. With this in mind the rate of regression of cardiac hypertrophy with time was determined in adult albino rats. The hypertrophy was induced by exposure to simulated high altitude. The percentage of hypertrophy was significantly greater (46 per cent) in the right ventricle than in the left (16 per cent). The time of regression was similar for both ventricles, that is, about 90 per cent complete in 21 days. Given sufficient time the heart presumably would return to its former normal size. It is noteworthy that even though the right ventricle showed almost three times as much hypertrophy as the left, regression occurred equally in both ventricles.

The clinical interpretation that can be made from this experiment is that it reaffirms clearly the fact that cardiac hypertrophy regresses when the factor which produced the enlargement is removed. There probably are, however, some conditions in the body when cardiac hypertrophy may not entirely regress, such as hypertrophy produced by long-standing hypertension, even though the blood pressure at a later time had been brought down to an acceptable level by antihypertensive agents. In such cases there is presumably not only muscle hypertrophy but also diffuse fibrosis, likely in response to chronic relative ischemia. Furthermore, heart enlargement produced by valvular injury may not regress entirely to normal size, even though surgery has relieved the valvular difficulty.

In the main, however, it is clinically important that the heart has the fundamental ability to regress to normal size if the factor which caused

the enlargement is removed. Equally important is the fact that in most instances, at least so far as we know, the heart shows no sign of physiologic injury.

1. Regression of Altitude-Produced Cardiac Hypertrophy. J. Applied Physiol. 35: 518-521, 1973. D. A. Sizemore, T. W. McIntyre, E. J. Van Liere and M. F. Wilson.

RUSH MEDICAL COLLEGE REACTIVATED

Graduates of Rush Medical College, and there are a number of them practicing in West Virginia, are doubtless pleased to learn that on June 15th of this past year Rush Medical College graduated its first class of 32 students since suspending its operation in 1942. Rush Medical College named after the famous Dr. Benjamin Rush, was founded March 2, 1837 (two days before the city of Chicago was incorporated). It is the oldest medical school in Illinois. For many years it was affiliated with the University of Chicago, but when the latter institution completed its Medical Center on the Midway, affiliation between the two schools ceased. In 1942 Rush Medical College closed.

Rush Medical College can lay claim to many famous medical men and women who have served on its faculty. Only two or three will be mentioned in this brief essay. James B. Herrick, M. D. (1861-1954) described coronary heart disease and was the first to demonstrate the pattern of coronary occlusion with an electrocardiogram. He also was the first physician to describe sickle-cell anemia. George F. Dick, M. D. (1881-1967) and Gladys Dick, his wife, developed methods of diagnosis and immunization against scarlet fever.

In October 1969 Rush Medical College was reactivated as part of Rush-Presbyterian—St. Luke's Medical Center. Medical students, some with advanced standing, matriculated in the autumn of 1971 and as previously stated 32 students were graduated on June 15, 1973.

One of the author's interest in writing this editorial on Rush Medical College is that for many years students from two-year medical schools, and West Virginia was one of them, transferred to Rush Medical College to complete their medical education. The closing of the school in 1942 was a serious blow to a number of two-year medical schools, and some of them experienced a difficult time to transfer their students. The situation is not as acute now, because presently there is only one two-year medical school, whereas in 1942 there were ten.

In December 1972 the Medical Center announced the formation of Rush University which encompasses: Rush Medical College, Rush College of Nursing and Allied Health Sciences, and Rush Graduate College. It should be emphasized that there is virtually limitless clinical material available for teaching purposes. Ultimately the Center is committed to produce 100 physicians, 500 nurses and a substantial number of allied health personnel each year.

It must be indeed gratifying to the graduates of Rush Medical College that their alma mater is reactivated. It has in the past produced many outstanding physicians and surgeons, and there is reason to believe now that the school is reactivated, its splendid tradition will be resumed.

Confidence in Doctors

Congress, the executive branch of government and millions of U. S. citizens will find much cause for alarm and some cause for hope in a congressionally-sponsored Louis Harris public opinion survey. The survey covered a wide range of topics and problems. Perhaps its most significant revelation is the abysmal lack of confidence in the federal government and most notably the executive branch.

The survey also revealed what will be a surprising fact to some. The medical profession stands highest in public esteem of all major institutions—above higher education, televisions news, the military, organized religion, the U. S. Supreme Court, the U. S. Senate, the press and major companies. The individual appears to place more trust in his doctor than anyone else.

This brings up highly-paradoxical phenomenon. On the one hand, medicine stands highest in public repute; and, on the other, government stands lowest. Yet there are those who crusade for government to take over the doctors under a sweeping national health insurance law. The proposed government health plans would put the medical profession and related health services under the jurisdiction of politicians who, as an institution, have received a no-confidence vote.

Clearly, whatever form the nation's health care plans take in the future, every safeguard should be set up to shield the independence of physicians and protect the sensitive position the medical profession holds in the lives and well-being of U. S. citizens. The catastrophic consequences of a collapse in the confidence of the individual in the traditional doctor-patient relationship allows no room for error in the evolution of the health care system.—*The Weirton Daily Times.*

The bulk of the cost of group health insurance for the nation's workers is currently being borne by their employers. Premiums for over half the workers covered under group medical plans in the U.S., according to the Health Insurance Institute, are now paid in full by employers. At the same time, the Health Insurance Association of America reports that fewer than 1 worker out of 100 pays the full cost of the group health insurance plan that he is covered by where he works.

GENERAL NEWS

Drs. Glenn and Mackenzie To Speak At 107th Annual Meeting

Dr. J. Hugh Wiley of Morgantown, Chairman of the Program Committee, has announced that Dr. James F. Glenn of Durham, North Carolina, and

Allen H. Mackenzie, M. D.

James F. Glenn, M. D.

Dr. Allen H. Mackenzie of Cleveland, Ohio, have accepted invitations to present papers during the 107th Annual Meeting of the West Virginia State Medical Association which will be held at The Greenbrier in White Sulphur Springs, August 21-24, 1974.

Doctors Glenn and Mackenzie will present papers at the second general scientific session on Friday morning, August 23. It also is anticipated that both physicians will be invited to speak before separate meetings of sections and affiliated societies.

James F. Glenn, M. D.

Dr. James F. Glenn, Professor of Urology at the Duke University School of Medicine, is a native of Lexington, Kentucky. He was graduated from the University of Rochester and received his M. D. degree in 1952 from the Duke University School of Medicine. He interned and served residencies at Peter Bent Brigham Hospital in Boston and at the Duke University Medical Center. He served for two years as a Captain in the Medical Corps of the U. S. Air Force.

Doctor Glenn served as a member of the faculty at Duke Medical Center, Yale University School of Medicine and was Associate Professor of Urology at the Bowman Gray School of Medicine from 1961 until 1963 when he assumed his present position.

He was certified by the American Board of Urology in 1962 and is a member of the American College of Surgeons and is a Past President of the Society of University Urologists. He is currently serving as Vice President of the Society of Pelvic Surgeons and as Chairman of the Committee on Continuing Education of the American Urological Association. He has served on the editorial boards of five scientific publications.

Allen H. Mackenzie, M. D.

Dr. Allen H. Mackenzie, who is a member of the staff of the Division of Medicine—Department of Rheumatic Disease—at The Cleveland Clinic Foundation and the Cleveland Clinic Hospital, is a native of Spartanburg, South Carolina.

He was graduated from Wofford College in South Carolina and received his M. D. degree in 1955 from the Tulane University School of Medicine. He interned at Charity Hospital of Louisiana in New Orleans and served for two years as a Lieutenant in the Medical Corps of the U. S. Navy. He served a residency at The Cleveland Clinic Foundation, 1958-61, and has been a member of the staff since that time.

He is a member of Phi Beta Kappa, the Cleveland Academy of Medicine, the Ohio State Medical and the American Medical Association. He is President of the Ohio State Rheumatism Society and is a member of the American Academy of Physical Medicine and Rehabilitation.

Senator Byrd to Deliver Keynote Address

It was announced previously that Sen. Robert C. Byrd of West Virginia had accepted an invitation to deliver the "Thomas L. Harris Address" at the opening of the first general scientific session on Thursday morning, August 22.

Three General Scientific Sessions

Doctor Wiley said there will be three scientific sessions on Thursday, Friday and Saturday mornings and that every effort possible will be made to keep Thursday and Friday afternoons open to enable everybody to enjoy the recreational facilities available at The Greenbrier. Members of the various sections and affiliated societies have been asked to hold breakfast meetings if they plan to meet during the Annual Meeting.

The Pre-Convention Meeting of the Council will be held on Wednesday morning, August 21, and the first session of the House of Delegates has been scheduled that afternoon. The final session of the House of Delegates will be held on Saturday afternoon, August 24.

Medical Institute Establishes Office in Charleston

The West Virginia Medical Institute, Inc., and its initial staff of three now have a "home" at 4701 MacCorkle Avenue, S. E., in Charleston.

Harry S. Weeks, Jr., M. D., of Wheeling, the Institute's President, said the organization occupied on February 1 offices formerly used by the Voluntary Office Self-Audit Service (VOSAS) medical education project.

Heading the staff as Executive Director is Charles R. Lewis, who provided staff assistance in developing the new corporation while serving first as Executive Assistant and then Projects Director of the West Virginia State Medical Association.

Other staff members are Mrs. Betty Kirkwood of Charleston and Mrs. Jean Albarran of Huntington, medical audit technicians for the VOSAS program developed by the West Virginia Regional Medical Program and the Medical Association.

Mrs. Kirkwood will have office manager and other supervisory duties. Mrs. Albarran, as training coordinator, will have primary responsibilities in development of manual and related material.

The Medical Institute, developed with basic continuing medical education objectives over a two-year period, also has been designed to handle the anticipated implementation in West Virginia of the 1972 Federal Professional Standards Review Organization (PSRO) statute.

That controversial legislation calls initially for evaluation by local physicians of the quality, necessity and appropriateness of institutional (hospital or nursing home) care provided in their areas under federally funded Medicare, Medicaid and Maternal and Child Health Programs.

Incorporated last September 4, and formally organized with election of trustees and officers last September 30, the Institute had a voluntary membership early in February of more than 650 doctors of medicine and osteopathy licensed and practicing in the state.

Initial staff activity will include further evaluation of the three-year initial phase of VOSAS, particularly from the standpoint of educational activity expected to stem from professional standards review.

The staff also has developed, for refinement beginning with a physician subcommittee of the Institute, a proposed state PSRO organization; and a model to help local hospital medical staffs develop or broaden professional review procedures in line with the new law.

Final U. S. Department of Health, Education and Welfare designation of West Virginia as a single PSRO area was anticipated by early to mid-March. HEW then has hopes of entering into intial contracts with physician organizations, such as the Institute, in several states by July 1 for further provisional implementation of the review program.

Meanwhile, the Institute has obtained Federal funds available through the Regional Medical Program and West Virginia University to complete its organization efforts, and to prepare for review and other assignments the future might bring.

RMP also provided funding and management control for the VOSAS program as it was operated in cooperation with the Medical Association and its Committee on Medical Education and Hospitals.

Correspondence with the Medical Institute should be addressed to Post Office Box 1031, Charleston 25324. The Institute telephone number is 925-7011.

Spring Meeting of Pediatric Chapter In Huntington, Mar. 20-21

The Spring Meeting of the West Virginia Chapter of the American Academy of Pediatrics will be held March 20-21 at the Holiday Inn East in Huntington.

The meeting will begin at noon on Wednesday, March 20 and conclude the following afternoon.

Irving Kushner, M. D.

John F. Kelley, M. D.

Speakers and their topics Wednesday afternoon will be "Office Management of Urinary Tract Infections," Dr. Kenneth L. Wible, Instructor in Pediatrics at West Virginia University School of Medicine; "Juvenile Rheumatoid Arthritis," Dr. Irving Kushner, Professor of Medicine and Chairman, Division of Rheumatology, WVU, and "Autism," Dr. John F. Kelley, Associate Professor, Behavioral Medicine and Psychiatry and Pediatrics, WVU, and Mrs. Ruth Sullivan.

There will be a banquet Wednesday evening and a business meeting Thursday morning.

Thursday speakers and topics will be "Infant Formulas," Dr. Samuel Foman, Professor of Pediatrics, University of Iowa; "Hyperlipidemias," Dr. George H. Khoury, Professor of Pediatrics and Director, Pediatric Cardiology, WVU; "Consideration of Growth," Doctor Foman, and "Recent Advances in Cystic Fibrosis," Dr. Ruth Phillips, Associate Professor of Pediatrics, WVU.

Two Meetings of Council Held During Month of January

Two meetings of the Council of the West Virginia State Medical Association were held in Charleston on successive weekends during the month of January. Dr. Worthy W. McKinney of Beckley, the Chairman, presided at both meetings.

The first meeting was held on Sunday, January 20, in conjunction with the Seventh Annual Mid-Winter Clinical Conference sponsored by the Association in cooperation with a number of other organizations.

The two main items on the agenda at both meetings of the Council pertained to (1) feasibility of the proposed second medical school under the sponsorship of Marshall University and the Veterans Administration in Huntington, and (2) a report on the 1974 session of the Legislature.

Proposed Marshall-VA Medical School

Doctor McKinney reminded members of the Council that Dr. A. Thomas McCoy, the President, and other officers of the Association had officially been requested by the President of the West Virginia Board of Regents and the Speaker of the West Virginia House of Delegates to supply an opinion in re the establishment of a second medical school in West Virginia sponsored by Marshall University and the Veterans Administration.

Following considerable discussion during the two meetings, the net result was the adoption of the following policy statement in re the proposed Marshall University-VA Medical School:

> "Following further consideration at a meeting held in Charleston on Sunday, January 27, 1974, the West Virginia State Medical Association supports the continued study of the feasibility of the proposed establishment of a medical school in West Virginia in conjunction with the Veterans Administration and Marshall University complex since this would offer an opportunity for the training of more West Virginia students for a career in medicine.
>
> "Also, the Council encourages the physicians of Cabell County to continue to put together facts for dissemination to the Association, its members and to the public. This statement represents the official policy of the Association as of this date."

The Executive Secretary was directed to deliver a copy of the above policy statement to the Hon. Frederick P. Stamp, Jr., President of the West Virginia Board of Regents; the Hon. Lewis N. McManus, Speaker of the West Virginia House of Delegates; Hon. William T. Brotherton, Jr., President of the State Senate; and the Hon. Arch A. Moore, Jr., Governor of the State of West Virginia.

Resolution In Re Statements By Association Officials

It was brought to the attention of Council that frequently officers and members of the Association are asked to express an opinion on matters of interest in the field of health and medical care. Following discussion, the following resolution was adopted unanimously by the Council:

> WHEREAS, The officers and members of the West Virginia State Medical Association are often asked to express an opinion on matters of interest in the field of health and medical care; and
>
> WHEREAS, Each physician has the right to express his personal opinion;
>
> THEREFORE, BE IT RESOLVED, That any member or officer of this Association shall have the right to state his own personal opinion; and
>
> BE IT FURTHER RESOLVED, That in speaking on behalf of the West Virginia State Medical Association that the officer or officers express only opinions that have been approved by the Council or House of Delegates of the West Virginia State Medical Association.

Meetings of Association Committees

Doctor McKinney reported that in recent months there had been some question concerning whose responsibility it was to call meetings of standing or special committees of the Association. He said that the following opinion concerning this issue was rendered by the Parliamentarian, Dr. James S. Klumpp of Huntington, during a telephone conversation on January 26, 1974:

> "It is common practice that the chairman of a committee can call a meeting at any time he wishes or it can be called upon request of the majority of the members, or upon the recommendation of the President of the Association."

Dr. F. Lloyd Blair of Parkersburg, noting that this language was not spelled out in the By-Laws of the Association, suggested that the By-Laws be amended during the Annual Meeting in 1974 to conform with the opinion rendered by the Parliamentarian. The suggestion was unanimously approved by Council.

Election of Honorary Member

The following physician was elected to honorary membership in the West Virginia State Medical Association at the meeting held on January 20:

Name	*Address*	*Society*
Arthur C. Litton	Charleston	Kanawha

Financial Help For SAMA Chapter at WVU

It was reported that the West Virginia University Chapter of the Student American Medical Association had requested that the Council make a contribution to the WVU Chapter to help send two delegates to the national SAMA meeting to be held in Dallas, Texas, February 28-March 2.

The Council voted to contribute $200 to the WVU Chapter and it was suggested that the Dean of the WVU School of Medicine be made aware of this fact inasmuch as the School also has helped to send delegates to SAMA meetings in the past.

Appropriation For Junior Academy of Science

It was reported that the coordinator of the West Virginia Junior Academy of Science had requested financial assistance to aid in supporting the activities of the Academy in 1974.

The Council voted unanimously to approve an appropriation of $100 to the Academy.

European Adventure

The Executive Secretary reported that final plans for the Association's European Adventure to Switzerland, Germany and Austria had been worked out and those persons who took advantage of past tours would receive a brochure and other information dated January 21. He said this same material would be sent to all members of the Association prior to the end of the month and that the departure date for the two-week trip is scheduled for July 24 from Dulles Airport in Washington, D. C.

Senator Byrd To Be Keynote Speaker

The Executive Secretary reported that Sen. Robert C. Byrd had accepted an invitation to be the keynote speaker at the 1974 Annual Meeting of the Association at The Greenbrier in August. He said that Senator Byrd would deliver the "Thomas L. Harris Address" at the opening scientific session on Thursday morning, August 22.

West Virginia Medical Institute, Inc.

Doctor McKinney called upon Dr. Harry S. Weeks, Jr., President of the West Virginia Medical Institute, Inc., to present a progress report on the Institute.

Doctor Weeks reported that officers of the Institute were pleased with the number of physicians and other interested individuals who attended the Professional Standards Review Organization Workshop which was held on Friday night, January 18. He also reported that a meeting of the Board of Trustees of the Institute was scheduled to be held that afternoon.

1974 Session Of The Legislature

Dr. Frank J. Holroyd, Chairman of the Legislative Committee, reported that due to confusion in utilizing a new computer system in the drafting of bills for the Legislature, only a small number of bills of interest to the profession had been introduced as of January 27.

He reported that a bill to provide a definite abortion law for West Virginia had been introduced and essentially was the same bill that almost was passed by the Legislature in 1973.

The Council voted to reaffirm the policy statements adopted by both the American Medical Association, West Virginia State Medical Association and the American College of Obstetrics and Gynecology.

There was discussion of several other bills which had been introduced and several officers of the Association were assigned the responsibility of reviewing same and requesting time to express views of the Association at hearings that might be called at a later date.

Meetings Well Attended

The Council meetings on both January 20 and January 27 were attended by virtually all officers and members of the Council and note was made of the fact that a number of invited guests appeared to present their views concerning various items on the agenda.

ACS To Hold Spring Meeting In Houston March 25-28

The American College of Surgeons will hold its second annual four-day Spring Meeting in Houston on Monday, March 25 through Thursday, March 28, at the Albert Thomas Convention Center and the Hyatt Regency Hotel.

The meeting will provide eight postgraduate courses, some of which will feature plenary sessions, followed by workshops to facilitate participation and discussion. A surgeon may choose one of four courses during the first two days of the meeting, and select another from four other offerings in the second two days.

The nine-hour postgraduate courses will be supplemented by two days of symposia, panels, lectures and motion pictures.

Industrial exhibits will be open in the Albert Thomas Convention Center on Monday, Tuesday and Wednesday, March 25-27, from 9:30 A.M. to 5 P.M.

The postgraduate courses will cover:

"Fluids and Electrolytes"—Henry Thomas Randall, M. D., Providence, Chairman, and Stanley J. Dudrick, M. D., Houston, Co-Chairman.

"Cardiovascular Surgery"—Vallee L. Willman, M. D., St. Louis, Chairman, and E. Stanley Crawford, M. D., Houston, Co-Chairman.

"Cancer"—Robert C. Hickey, M. D., Houston, Chairman, and Richard H. Jesse, M. D., Houston, Co-Chairman.

"Plastic Surgery"—Maurice J. Jurkiewicz, D. D. S., M. D., Atlanta, Chairman, and Frank J. Gerow, M. D., Houston, Co-Chairman.

"Shock"—William R. Drucker, M. D., Charlottesville, Chairman, and Charles R. Baxter, M. D., Dallas, Co-Chairman.

"Gastrointestinal Surgery"—Rene B. Menguy, M. D., Rochester, N. Y., Chairman, and Paul H. Jordan, Jr., M. D., Houston, Co-Chairman.

"Surgery of the Hand"—Harold E. Kleinert, M. D., Louisville, Chairman, and Frederick B. Kessler, M. D., Houston, Co-Chairman.

"Urologic Surgery"—Russell Scott, Jr., M. D., Aspen, Chairman, and C. Eugene Carlton, Jr., Houston, Co-Chairman.

Fees for the postgraduate courses, approved by the American Medical Association for credit as continuing education courses, is $40 for all registrants, manual included. Registration for this meeting is a prerequisite for registering in the postgraduate courses.

Registration for the meeting will be free of charge to Fellows of the College whose dues are paid through 1973, members of the ACS Credentials Group, and surgical residents. Non-Fellows, applicants for Fellowship and Fellows whose dues have not been paid, pay $50. Non-Fellows in the Federal Services (full-time) pay $30.

Registered nurses and interns who present proper credentials may register free of charge for the general sessions and exhibits, but are not eligible for the postgraduate courses.

Family Physicians To Hold Scientific Assembly

Some 14 physicians will speak at the 22nd Annual Scientific Assembly of the West Virginia Chapter of the American Academy of Family Physicians next month in Charleston. The meeting will be held April 5, 6 and 7 at the Charleston House, Holiday Inn. It will open at 8:30 A. M. Friday, April 5, and conclude on Sunday at 12:30 P. M.

Walter M. Kirkendall, M. D.

Dr. Donald P. Brown of Kingwood, President of the State Chapter, and Dr. James G. Price of Brush, Colorado, President of the national AAFP, will be speakers at the Annual Banquet Saturday evening. Doctor Price also will install new officers. Dr. J. Edward Jackson of St. Albans will be toastmaster.

Scientific speakers will include Dr. O. Lee Trick, Assistant Chairman of the Department of Behavioral Medicine and Psychiatry, West Virginia University School of Medicine, and Resident Director, Charleston Area Medical Center Program; Mrs. Reita Troum, Assistant Director and Assistant Professor, Director of Family Therapy, Department of Behavioral Medicine and Psychiatry, WVU;

Drs. Robert A. Hawkins, Practicing Dermatologist, Charleston; George E. Ehrlich, Professor of Rehabilitation Medicine, Temple University School of Medicine; William A. Stowe, Dayton, Ohio; Edward J. Shahady, Director of the Department of Family Practice, Akron (Ohio) City Hospital; Mitchell A. Spellberg, Professor of Medicine, Pritzker School of Medicine of the University of Chicago;

Donald P. Brown, M. D.

William D. Crigger, M. D.

Walter M. Kirkendall, Professor and Director of the Program in Internal Medicine, University of Texas Medical School, Houston; Herbert A. Selenkow, Consultant, Endocrinology and Metabolism Advisory Committee, FDA, Washington, D. C.; Robert D. Patchell, Director of Obstetrics, Charleston Area Medical Center; James E. Boggs, Practicing General Surgeon, Charleston; John D. Zeedick, anesthesiologist, Herbert J. Thomas Memorial Hospital, South Charleston; Doctor Price, and John W. Traubert, Director of the Department of Family Practice, WVU.

Dr. William D. Crigger of South Charleston, President Elect, is Program Chairman. The Annual Assembly has been approved for 17 hours of credit in Category 1 by the AAFP.

There will be a Board of Directors Meeting on Thursday at 7 P. M. and on Sunday at 1 P. M. The House of Delegates will meet on Friday from noon to 1:30 P. M. There will be a cocktail party on Friday evening.

There will be a registration fee of $30 and a banquet and cocktail fee of $12.50 per person. No registration fee will be charged for nurses, interns and students.

Board of Family Practice Names New Officers, Directors

The American Board of Family Practice has named new officers and directors. The Board is the certifying body in the new specialty of family medicine.

Elected at the January semi-annual meeting were Arthur D. Nelson, M. D., Phoenix, Arizona, President; George E. Burket, Jr., M. D., Overland Park, Kansas, Vice President; Nicholas J. Pisacano, M. D., Lexington, Kentucky, reelected Secretary, and the following Directors: Robert E. Rakel, M. D., Iowa City, Iowa (from the American Academy of Family Physicians); Herbert A. Holden, M. D., San Leandro, California (from the Section on Family General Practice, American Medical Association), and Ralph Benson, M. D., Portland, Oregon (from the American Board of Obstetrics and Gynecology).

The officers will serve one-year terms. The new Directors will serve four-year terms.

The Board of Family Practice was set up in February, 1969, following approval by the American Board of Medical Specialties. Family practice, an outgrowth of general medical practice but developed to incorporate "comprehensive and continuing care of patient-families," is the latest (No. 20) of the primary medical specialties. Other such medical specialty disciplines include surgery, internal medicine, pediatrics, obstetrics and gynecology, and others.

The primary role of the Board of Family Practice is to set standards and provide and administer a certifying examination in the specialty. Four such examinations have been held and more than 5,800 physicians have been certified. Those passing the two-day examination are called "Diplomates." The specialty of family practice is the only one requiring recertification. Diplomates must be recertified every six years.

Seventh Mid-Winter Conference Attendance Up By 100

Registration for the Seventh Mid-Winter Clinical Conference held January 18-20 in Charleston showed an increase in attendance of almost 100 persons—not including still another estimated 230 lay people who attended the Friday night public session.

The total registration for the Conference was 231 while 144 were in attendance the previous year. The Conference this year attracted 154 practicing physicians, in contrast to 121 in 1973.

Drs. Ralph H. Nestmann and Joseph T. Skaggs of Charleston, Conference Co-Chairmen, attributed the record attendance at this year's Conference to the newly-added Friday night concurrent sessions and a growing number of sponsors as well as to the over-all interest in the program topics and speakers.

On Friday night this year approximately 230 lay persons and some 20 health care personnel attended the public session on "The Battered Child" while almost 100 physicians were in a concurrent PSRO Workshop. The Friday evening public session was sponsored and promoted by the Woman's Auxiliary to the Kanawha Medical Society.

In addition to the 154 practicing physicians, this year's registration breaks down to 42 nurses, six residents, four physician's assistants, two medical students, one intern, one Ph. D. and 21 other health and related personnel.

The Conference was acceptable for credit toward the Physician's Recognition Award of the American Medical Association—and for 12 hours of elective credit by the American Academy of Family Physicians.

Held at the Heart-O-Town Motor Inn, the 1974 Clinical Conference was sponsored by the West Virginia State Medical Association and 13 affiliated and other medical-health groups and institutions.

New officers of the Kanawha Medical Society shown above were presented at the Society's annual dinner dance and installation of officers held on January 19 in Charleston at the Daniel Boone Hotel. From left, are Drs. Joseph T. Skaggs, Secretary-Treasurer; A. Thomas McCoy, President of the West Virginia State Medical Association who was special guest at the affair; John B. Markey, President; and George A. Shawkey, Vice President; all of Charleston.

Participating in the panel discussion on "The Battered Child" at the Seventh Mid-Winter Clinical Conference held in Charleston January 18-20 were, seated, from left, the principal speaker, Dr. Eli H. Newberger, Director of Family Development Study at Children's Hospital Medical Center in Boston; Dr. Herbert H. Pomerance, Director of Pediatrics, Charleston Area Medical Center, who presided and served as Moderator; Patricia O'Reilly, Ph. D., psychologist, Kanawha County Schools, Charleston; standing, from left, Dr. John F. Kelley, Associate Professor of Behavioral Medicine and Psychiatry and Pediatrics at the West Virginia University School of Medicine; Mr. Patrick B. O'Neal, Assistant Prosecuting Attorney, assigned to Juvenile Court of Kanawha County, Charleston; Mr. Julian Sulgit, Director, Bureau of Child Protective Services, West Virginia Department of Welfare, Charleston; and Dr. Carl J. Roncaglione, Charleston orthopedic surgeon.

AAP Spring Session Scheduled In Florida, Apr. 22-25

More than 2,000 child health professionals from throughout the hemisphere are expected to attend the American Academy of Pediatrics' annual Spring Session at the Americana Hotel in Bal Harbour, Florida, April 22-25, 1974.

The scientific sessions, open to all registrants, will feature discussion on a variety of topics, including learning disabilities, trauma, care of the burned child, advances in immunization, and the effects of televised violence on children.

A special plenary session will be devoted to the adolescent, with discussions of the ethics and mores of the adolescent, the truth about food and vitamins, and how to communicate with adolescent patients.

In addition, round table discussions will include problems of office management, and management of pediatric emergencies. Other round tables will discuss pediatric nephrology, neurology, hematology, dermatology, ophthalmology and neonatology.

The Academy is the Pan-American association of physicians certified in the care of infants, children and adolescents. The Academy has approximately 15,000 members in North and South America.

In the left photo, Dr. Donald E. Cunningham of St. Albans, right, chats with Dr. Robert D. Patchell, Professor and Director of Obstetrics and Gynecology, Charleston Division, WVU School of Medicine. Doctor Patchell was a Sunday afternoon speaker at the Seventh Mid-Winter Clinical Conference held in Charleston January 18-20 at the Heart-O-Town Motor Inn. In the right photo, Dr. Pat A. Tuckwiller of Charleston, center, has a discussion with two Conference participants. Doctor Tuckwiller is Chairman of the State Medical Association's Committee on Medical Education and Hospitals.

In the left photo, Dr. Ralph H. Nestmann, left, Co-Chairman for the Seventh Mid-Winter Clinical Conference, talks with Dr. John E. Jones, Dean of the WVU School of Medicine, who presided at the Sunday afternoon session. In the center photo are physicians from the WVU School of Medicine who participated in the Sunday morning session. From left, they are Drs. Jack L. Le Frock, Assistant Professor of Medicine, Division of Infectious Diseases; Raymond B. Weiss, Assistant Professor of Medicine; Irving Kushner, Professor of Medicine and Chairman, Division of Rheumatology; and Hartwell G. Thompson, Dean of the Charleston Division, who presided. In the right photo, Dr. George F. Evans of Clarksburg, left, talks with Dr. Charles B. Kahn, physician with the Joslin Clinic and Assistant Professor of Medicine at Harvard Medical School in Boston, who was a guest speaker Saturday afternoon.

Among those attending the Seventh Mid-Winter Clinical Conference held in Charleston January 18-20 were, in the left photo, at left, Dr. John L. Guerrant, Professor of Medicine and Chief of Allergy and Pulmonary Disease Section of the Department of Internal Medicine at the University of Virginia School of Medicine, Charlottesville, who was a Saturday afternoon speaker, and Dr. A. Franklin White of Louisville, Kentucky. In the center photo, Mr. Charles E. Sikorski, left, Executive Director of the American Heart Association, West Virginia Affiliate, has a discussion with Dr. Ray W. Gifford, Jr., Head of the Department of Hypertension and Nephrology at the Cleveland Clinic Foundation, a Saturday afternoon speaker. In the right photo are Dr. E. Gordon Margolin, left, Director of the Department of Internal Medicine at the Jewish Hospital, Cincinnati; and Dr. Joseph T. Skaggs of Charleston, Conference Co-Chairman.

Dr. Richard E. Flood Named To National Board

Dr. Richard E. Flood of Weirton has been elected to a two-year term on the Board of Directors of the Federation of State Medical Boards of the United States.

He was elected during a business meeting of the Board held early in February in Chicago at which time the Federation installed Dr. Howard L. Horns of Minneapolis as its President.

Richard E. Flood, M. D.

The national organization is made up of representatives of state medical licensing boards, and Doctor Flood has been a member of the West Virginia Medical Licensing Board since 1969. He also served as President of the West Virginia State Medical Association in 1966-67.

In continued efforts toward more uniform state medical licensing laws, the program at the Chicago meeting dealt with such subjects as medical education and continuing education and the Federation Licensing Examination (FLEX).

Dr. Steven A. Artz Named President Of State Diabetes Assn.

Dr. Steven A. Artz of Charleston was elected President of the West Virginia Diabetes Association during the annual business meeting which was held at the Heart-O-Town Motor Inn in Charleston on January 19, 1974.

Other officers elected are as follows: Mr. John M. Panza of Fairmont, President Elect; Dr. John H. Gile of Parkersburg, Vice President; and Mrs. Alan M. Arthur of Charleston, Secretary-Treasurer.

Clinical Endocrinology Course At Mayo Clinic in April

A postgraduate course of the American College of Physicians, "Clinical Endocrinology: Recent Advances in Diagnosis and Treatment," will be held April 15-19 at the Mayo Clinic in Rochester, Minnesota.

This course is designed for the physician with a special interest in clinical endocrinology. Its objective is to present material which is not readily available in standard textbooks on endocrinology, but which is essential to the current understanding, diagnosis, and managements of endocrine problems.

Emphasis will be placed on newer concepts of pathogenesis, the selection and interpretation of diagnostic tests and the application of the results of recent clinical and laboratory investigations to the management of patients with endocrine disease.

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled in the coming months.

1974

Mar. 1-3—Student Am. Med. Assn., Dallas.
Mar. 7-9—Central Surg. Assn., Cincy.
Mar. 15-17—AMA-AMPAC Pub. Affairs Workshop Washington, D. C.
Mar. 20-21—W. Va. Chap. Am. Acad. Pediatrics, Huntington.
Mar. 22-23—Am. Assn. of Ob.-Gyn., Los Angeles.
Mar. 24-25—Am. Soc. Clinical Pharmacology and Therapeutics, Maui, Hawaii (San Francisco, Mar. 28-29).
Mar. 25-28—Am. Coll. Surgeons, Houston.
Mar. 28-29—Am. Bd. Med. Specialties, Chicago.
Mar. 28-30—Am. Assn. for Cancer Research, Philadelphia.
Mar. 29-April 3—Am. Soc. Abdom. Surgeons, Las Vegas.
Mar. 31—April 5—Am. Coll. Physicians, N. Y.

April 1-5—Am. Coll. of Rad., New Orleans.
April 5-7—W. Va. Chapter, AAFP, Charleston.
April 7-12—Am. Assn. Immunologists, Atlantic City.
April 8-11—S.E. Surgical Congress, Atlanta.
April 10-13—Tenn. Med. Assn., Gatlinburg.
April 17-19—Maryland Medical, Baltimore.
April 17-20—W. Va. Acad. of Ophth. and Otol., White Sulphur Springs.
April 20-25—Am. Assn. of Neur. Surg., St. Louis.
April 22-24—Am. Assn. Thoracic Surgery, Las Vegas.
April 22-25—Am. Acad. Pediatrics, Bal Harbour, Fla.
April 22-27—Am. Acad. of Neur., San Francisco.
April 29-May 2—Am. Coll. Ob.—Gyn., Las Vegas.

May 1-3—Am. Surg. Assn., Colorado Springs.
May 1-4—W. Va. Chapter, ACS, White Sulphur Springs.
May 12-15—Am. Thoracic Soc., Cincy.
May 12-15—S. Carolina Med. Assn., Myrtle Beach.
May 12-15—Ohio State Med. Assn., Cleveland.
May 12-16—Am. Assn. Plastic Surgeons, Seattle.
May 16-18—Childhood Cancer, Dallas.
May 17-18—Am. Assn. Clin. Urologists, St. Louis.
May 19-22—Am. Ophthal. Soc., Hot Springs, Va.

June 3-6—Int. Convo. Immunology, Buffalo, N. Y.
June 10-12—Am. Neuro. Assn., Boston.
June 15-16—Am. Diabetes Assn., Atlanta.
June 23-27—AMA, Chicago.

July 25-27—Am. Electroencephalographic Soc., Seattle.
July 28-Aug. 1—Natl. Med. Assn., N. Orleans.

Aug. 12-15—Am. Hosp. Assn., Chicago.

Aug. 21-24—107th Annual Meeting, W. Va. State Medical Assn., White Sulphur Springs.

Sept. 4-7—Am. Assn. Ob.-Gyn., Hot Springs, Va.
Sept. 16-19—Ky. Med. Assn., Louisville.
Sept. 18-21—Am. Thyroid Assn., St. Louis.

Oct. 14-17—AAFP, L. A.

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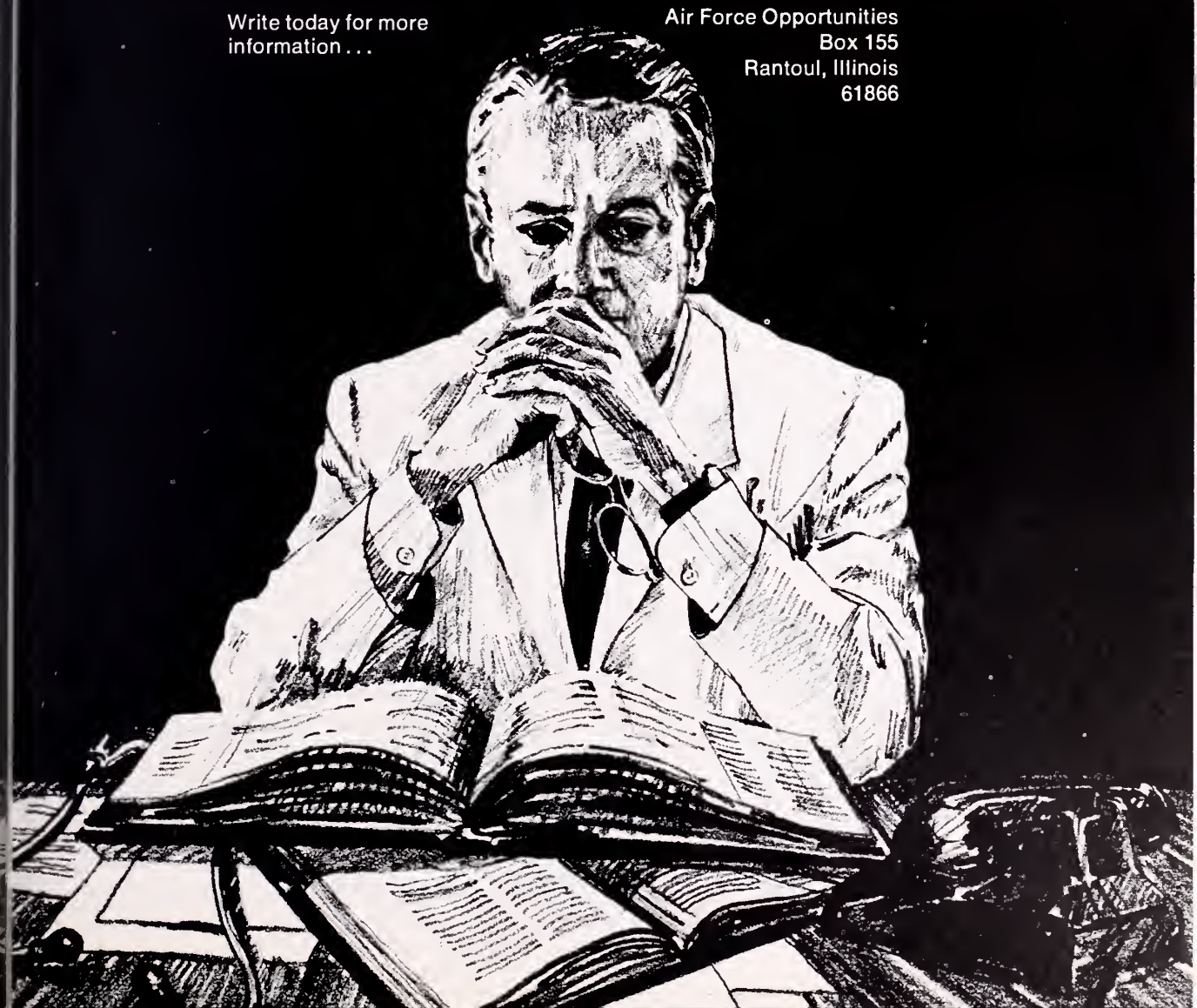


WVU Medical Center
–News–

April 20 is the date set for the Second Annual Symposium on Histopathologic Techniques sponsored by the West Virginia University Schools of Medicine and Dentistry.

Visiting lecturers for the Medical Center program will be Lee G. Luna, Chief of the Histopathology Laboratories Division of the Armed Forces Institute of Pathology, and Phillip Womack, Histology Supervisor of Pathology Consultants in Lynchburg, Virginia.

Also participating in the symposium will be pathologists and histotechnologists from WVU Medical Center and the Appalachian Laboratories for Occupational and Respiratory Diseases.

Registration at 8 A.M. will be followed by short talks by Ordie H. King, Jr., oral pathologist, and Anne Sharpe, Chief Histotechnologist at the Surgical Pathology Laboratory of the WVU Medical Center.

Luna's talk on "Staining Solution Stability" will be followed by "Diagnostic Application of Special Bone Marrow Stains," by Dr. Robert S. Salisbury, Department of Pathology; Womack's lecture on "An Alternative Method to Zenker Fixation," and "Celloidin Section Technique," by Elsie Syner of the Department of Anatomy.

Afternoon speakers and topics will be: Patsy Willard, ALFORD histotechnologist, "Modified Gough Section Techniques"; Luna, "Tissue Artefacts Affecting Pathologic Interpretation"; Dr. John A. Jupin, Department of Pathology, "Modification of Movats Pentachrome Stain," and Robert J. McTaggart, Department of Pathology Chief Cytotechnologist, "Preparation of Specimens for Cytologic Evaluation."

No registration fees are being charged for the program which will be of primary interest to physicians, histotechnologists and paramedical personnel. Persons wishing to attend are being asked to contact Marilyn Kent, Oral Pathology, WVU Medical Center, Morgantown 26506.

Child Psychiatry Clinic

Tom, an eight-year-old, is failing in school although he has a normal IQ. He is depressed and unable to get along with other children.

His brother, Jack, four years younger, is just the opposite—happy and outgoing.

Shortly after Jack's birth, the parents had punished Tom for displaying jealousy of his brother. Tom soon found it impossible to do anything that pleased them.

• **Compiled from material furnished by Mrs. Mary Ellin Wylie, Director, Medical Center News and Information Services, Morgantown, W. Va.**

Now their attitude fluctuates between optimism that he will "grow out of it," threatened punishment unless he "straightens up," and bitter resignation.

This case, which involves complex family interactions, is hypothetical. The school and family conflicts which it illustrates are not—they occur in greater or lesser degree in many homes.

Children like Tom need help before they become socially withdrawn or hopelessly mired in feelings of inadequacy.

Such help is available in the Child Psychiatry Clinic at West Virginia University Medical Center. A division of the Department of Behavioral Medicine and Psychiatry, WVU School of Medicine, the program has a two-fold purpose: to help problem children and their families and to train psychiatrists, medical students, psychologists, social workers and related health personnel to recognize and treat a variety of emotional divergences.

The division and its clinic is headed by Dr. John F. Kelley, Associate Professor of Behavioral Medicine and Psychiatry and Pediatrics.

Most problem children, according to Doctor Kelley, are not "sick," "disturbed" or "mentally ill," but simply have problems with living.

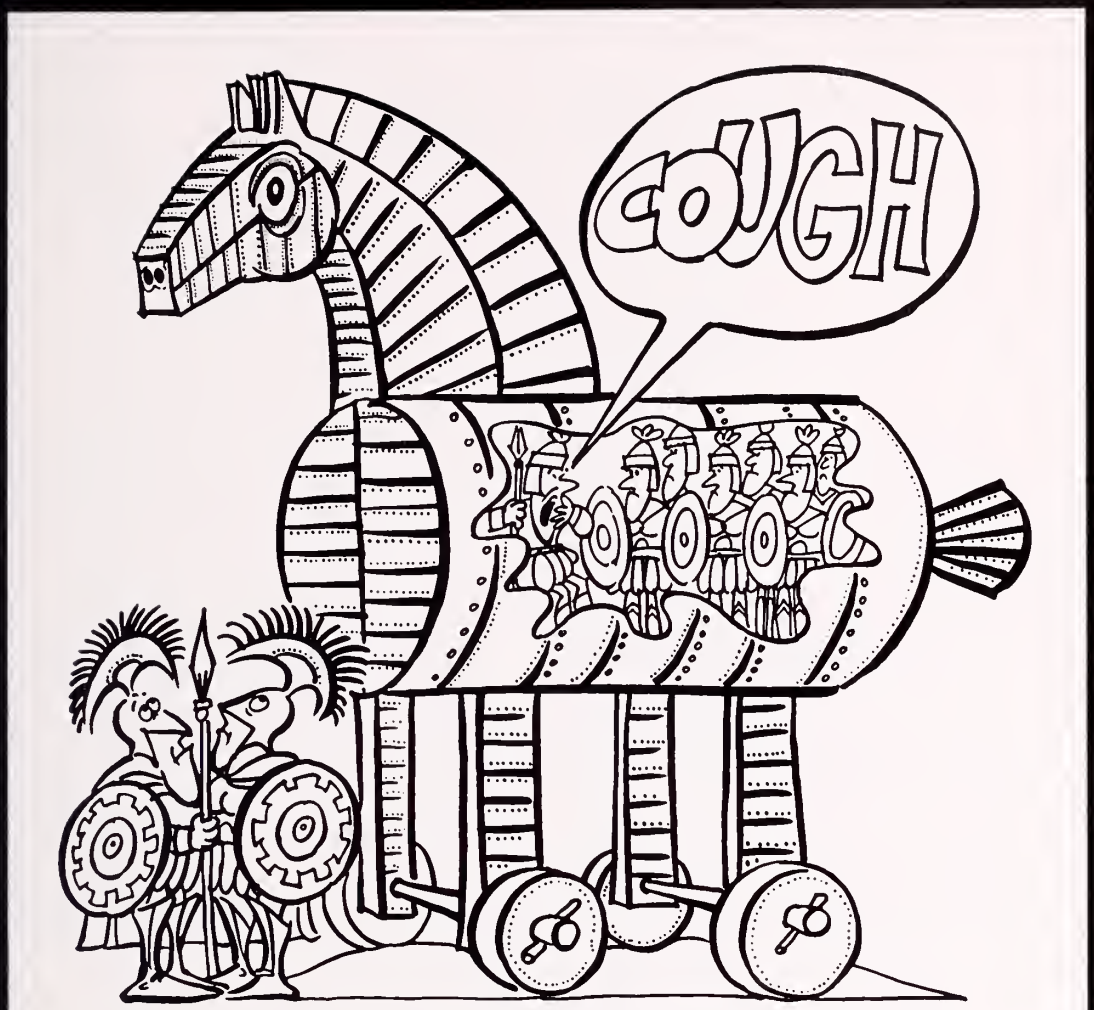
The severely psychotic child, who is withdrawn, has hallucinations or extremely bizarre behavior, is also seen at the clinic although hospitalization, in some cases, may be required either initially or later.

Doctor Kelley believes, however, that many seriously disturbed children can be cared for in their homes and receive psychiatric therapy on an outpatient basis.

Far outnumbering these patients are the problem children who are unwilling or unable to make adjustments to everyday living. This lack of adjustment most often manifests itself in what psychiatrists term "exaggerated forms of normal behavior."

The Child Psychiatry Clinic as an entity has been open since the spring of 1973, although children referred by their family doctors have been seen in the Behavioral Medicine and Psychiatry Clinic since Doctor Kelley joined the staff in 1968.

The child psychiatrist training program was approved and started in mid-1973. One resident, Dr. Charles F. Marsh, is now in the program.



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BO–SB

The Month in Washington

• **From the Washington Office of the American Medical Association.**

THE American Medical Association has branded as "wrong medically, wrong morally, and wrong legally" the Health, Education, and Welfare Department's proposed regulation requiring pre-hospital-admission certification for Medicare and Medicaid patients.

In what appeared as an ending to a "deliberate effort on the part of the AMA over the past four or five years to cooperate with HEW," the Association announced that if the pre-admission certification regulation and the Professional Standards Review Organizations area designations were placed into effect, HEW Secretary Caspar Weinberger would be taken into court.

(Please refer to latest information on pre-certification which has been published in *American Medical News*).

AMA President Russell B. Roth, M. D., and Board Chairman James H. Sammons, M. D., at a press conference in Chicago made the following statement:

"We are here today to serve notice on Secretary Weinberger that if he proceeds with two proposed actions, we are going to take him to court.

"Earlier this month, the Secretary of the Department of Health, Education, and Welfare issued a set of proposed regulations that would require pre-admission certification for Medicare and Medicaid. If adopted as proposed they would require that every Medicare and Medicaid patient be cleared by a Utilization Review Committee before admission to a hospital. The only exception would be emergency cases.

"These regulations are a direct threat to the medical care of the 35 million or so patients who are served by Medicare and Medicaid. For most of them, the withholding of Medicare or Medicaid hospital benefits will mean that the individual will be denied hospitalization because they have no other means to pay for their care.

"Furthermore, such decisions would not be made on the basis of an examination of the patient by physicians. Rather, they would be paper decisions. The verdict would be rendered on the basis of what the patient's doctor put down on the record. It is likely that, as a practical matter in many instances, the decision would not be made by a committee of physicians or even a single physician but by an admitting nurse or other hospital administrative personnel.

"Any such denial of medical care represents a clear violation of both the spirit and the letter of the Medicare-Medicaid law. Congress clearly established the programs to provide medical care for the elderly and the poor. What the Congress has given, the Secretary now seeks to take away. The Secretary has no authority under the guise of regulations to amend the law and reduce benefits. He has no moral or legal right or authority to do so. Indeed, his action is as illegal as it is reprehensible. The Medicare-Medicaid law provides for pre-admission certification by the patient's physician and for post-admission review by hospital utilization review committees. The Congress did not intend that a committee substitute a paper decision for the judgment of a patient's physician. The Secretary's proposal is a direct and clear violation of Section 1801.

To Resist PSRO Area Designations

"While we are in a suing mood, let me mention that we are also going to take on Mr. Weinberger in another area.

"This involves his gerrymandering of the PSRO district. Without getting too involved, let me say for those of you who don't know, PSRO stands for Professional Standards Review Organizations. These are supposed to be groups of doctors set up to review the quality and medical necessity of care given under Medicare and Medicaid.

"The AMA originally opposed PSRO. But once it became law, we decided that if such review was going to be done it would be better for all concerned if it were done by physicians.

"Peer review—the concept on which PSRO is based—was invented by the medical profession and was in existence long before the government ever heard of the idea. There are many excellent and functioning peer review programs now in effect in this country, and we asked the Secretary to set up the PSRO designated areas (regional units) so as not to disturb them.

"This plea apparently fell on deaf ears. I won't hazard a guess as to the reason behind the Secretary's area designations. I don't think there were any. I think the decision was simply capricious and arbitrary."

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Obituaries

A. B. CARR, M. D.

Dr. A. B. Carr of War, President of the McDowell County Board of Education and a former President of the McDowell County Medical Society (1950), died on January 13 in a Welch hospital following a long illness. He was 76.

Active in McDowell County civic affairs, Doctor Carr had been a member of the McDowell County Board of Education for 23 years and served as President for the past 14.

Governor Arch A. Moore, Jr., recently awarded him with a citation as a "Distinguished Citizen of West Virginia." In 1971, residents of the Big Creek District had an appreciation meeting for Doctor Carr to honor him for services throughout the years.

Born at New Hope, in Mercer County, Doctor Carr did undergraduate work at Concord State Normal School at Athens and at Emory and Henry College in Virginia. He received his M. D. degree in 1921 from the Medical College of Virginia. Upon graduation from medical college he joined a brother, the late Dr. W. A. Carr, as a physician at War.

Survivors include the widow; one daughter, Mrs. Christine McGuire of War, and one son, Dr. Arthur Allen Carr of Welch.

* * * *

ROSS P. DANIEL, M. D.

Dr. Ross P. Daniel of Beckley was found dead following a fire at his home on February 9. He was 75. His son, Robert N. Daniel, a Beckley real estate broker, also died in the fire.

A native of Bramwell, in Mercer County, Doctor Daniel was a graduate of West Virginia University and received his M. D. degree in 1924 from the University of Tennessee College of Medicine. He had practiced in Raleigh County and was a member of the Raleigh County Medical Society, the West Virginia State Medical Association and the American Medical Association.

Doctor Daniel was active in the affairs of organized medicine on both the local and state levels for many years.

Survivors include the widow, Mrs. Edith B., a Past President of the Woman's Auxiliary to the State Medical Association; and two sons, Ross P. Daniel, Jr., and Dr. C. Richard Daniel, both of Beckley.

* * * *

J. J. JENKINS, SR., M. D.

Dr. J. J. Jenkins, Sr., who practiced medicine in Farmington, in Marion County, for more than 50 years, died on January 9 at his home there. He was 86.

Born in Uffington, in Monongalia County, Doctor Jenkins graduated from West Virginia University and received his M. D. degree in 1914 from the University of Maryland College of Physicians and Surgeons. He started his practice on Statler Run near Morgantown, moving to Farmington in 1917.

He was an honorary member of the Marion County Medical Society, of which he was a former Vice President; the West Virginia State Medical Association and the American Medical Association.

Survivors include the widow; two sons, Dr. J. J. Jenkins, Jr., of Fairmont and Etley P. Jenkins of Morgantown. He was preceded in death by two sons, Neil, who was lost in World War II, and Robert E. Jenkins.

* * * *

CHARLES A. JONES, M. D.

Dr. Charles A. Jones, a retired physician of the Clarksburg Veterans Administration Hospital, died on January 1 in a Clarksburg Hospital. He was 65.

He was a former Chief of Staff at the VA Hospital and Professor of Internal Medicine at the West Virginia University School of Medicine. He retired April 1, 1971.

Survivors include the widow and one sister, Mrs. Benson Gyton of Decatur, Alabama.

* * * *

FREDERICK D. KELLER, M. D.

Dr. Frederick D. Keller of Belpre, Ohio, a former member of the West Virginia State Medical Association, died on January 16 in a Parkersburg hospital. He was 69. He practiced medicine in Paden City, West Virginia from 1931 to 1942 and at Omar, in Logan County, from 1946 to 1953.

Doctor Keller was a graduate of West Virginia University and received his M. D. degree in 1930 from the University of Maryland School of Medicine.

Survivors include a sister, Mrs. Helen Wieder of Parkersburg.

* * * *

SAMUEL B. SOULEYRET, M. D.

Dr. Samuel B. Souleyret of Cabin Creek, in Kanawha County, died on February 1 in a Charleston hospital following a short illness. He was 75.

Doctor Souleyret had been a family physician in the Cabin Creek area since 1927. He was on the staff of the Charleston Area Medical Center's Memorial and General Divisions. He was a Fellow of the American Academy of Family Physicians.

Doctor Souleyret received his M. D. degree in 1925 from the University of Louisville School of Medicine. He was an honorary member of the Kanawha Medical Society and a member of the West Virginia State Medical Association, the American Medical Association and the Southern Medical Association.

(Continued on page xv)

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OBITUARIES—(Continued)

Surviving are a daughter, Mrs. Betsy Howard of East Bank, and two sisters, Mrs. Realie Quenon of Fairmont and Mrs. Mabel R. Harness of Miami, Florida.

* * * *

JOHN O. THEISS, M. D.

Dr. John O. Theiss, a physician in New Martinsville for 50 years, died on January 11 at his home there. He was 77.

A native of Great Bend, Ohio, Doctor Theiss was a founder of the Wetzel County Hospital in New Martinsville and a Past President of the Wetzel County Medical Society (1950).

Doctor Theiss was a graduate of West Virginia University and received his M. D. degree in 1922 from the University of Cincinnati. He interned at Akron (Ohio) City Hospital and served a residency at the University of Michigan Medical School.

In addition to the county society, Doctor Theiss also was a member of the West Virginia State Medical Association, the Ohio Medical Association and the American Medical Association.

He was a director of the New Martinsville Bank.

Survivors include the widow; one son, Joe Theiss of New Martinsville, and two sisters, Olga and Norma Theiss of Ravenswood.

Rheumatic Diseases Symposium At U. of Louisville

The 10th Annual Postgraduate Symposium on Rheumatic Diseases will be held on Thursday, May 9 in the auditorium of the Health Science Center, University of Louisville School of Medicine.

For additional information write: David H. Neustadt, M. D.; Chief, Section on Rheumatic Diseases, University of Louisville School of Medicine, Louisville, Kentucky 40202.

PG Courses at U. of Kentucky Are Listed Through May

The University of Kentucky College of Medicine has announced courses during the coming weeks to be held at the Medical Center in Lexington.

The courses are:

"Colposcopy Seminar," March 26-27. Registration fee: $200.

"A Current Evaluation of an Old Problem: Diabetes Mellitus," April 5. Registration fee: $15.

"Practical Therapeutics in Internal Medicine," May 27-31. Co-sponsored by the American College of Physicians. Registration fee: $140 for ACP Members; $70 for ACP Associates, and $200 for non-members.

For further information contact Ronald D. Hamilton, M. D., Director, Continuing Education, College of Medicine, University of Kentucky, Lexington, Kentucky 40506.

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County Societies

HARRISON

An interesting program on the alcoholic was presented by Mrs. Libby Harper at the February 7 meeting of the Harrison County Medical Society at the Stonewall Jackson Hotel in Clarksburg. Mrs. Harper, from the Alcohol and Drug Abuse Unit in Harrison County, spoke on recognizing the alcoholic and how he can be helped.

The Society passed unanimously a motion by Dr. L. Dale Simmons that special membership in the Society be free to residents.

A memorium was read for the late Dr. William T. Gocke.—Ray A. Harron, M. D., Secretary.

* * * *

FAYETTE

Dr. William O. McMillan, Jr., of Charleston, spoke at the meeting of the Fayette County Medical Society on January 23 at the Oak Hill Hospital in Oak Hill. Doctor McMillan made a very interesting presentation on gastroscopy and other relatively non-invasive techniques of gastrointestinal diagnosis.

The next regular meeting of the Society was set for February 20 in Oak Hill with Dr. Hartwell Thompson of Charleston as the guest speaker.—Carl R. Adkins, M. D., Secretary.

* * * *

McDOWELL

The McDowell County Medical Society met on January 9 at Doctor's Memorial Hospital in Welch.

The Program Chairman, Dr. Guy E. Irvin, was absent because of illness. A film he had on "Depression," however, was presented.

A letter from the West Virginia Medical Institute, Inc. was read stating that West Virginia will be a single PSRO area under designations proposed by the U. S. Department of Health, Education and Welfare. The West Virginia Medical Institute, which is implementing PSRO in West Virginia, reported a membership of 585 doctors as of last December 28. The membership of this County Society was encouraged to join the Institute.

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The Society voted to continue its participation in the program of sending *The West Virginia Medical Journal* to students from our area enrolled in the West Virginia University School of Medicine. These students are: Michael W. Hansen, Charles J. Mirable, Ronald B. Dalton, William M. Mentz, Virginia S. Villani and Sheryl L. Linkous.—A. A. Carr, M. D., Secretary.

MERCER

The Mercer County Medical Society met on January 24 in Bluefield at the University Club.

Mrs. Gene Jones gave an interesting talk about the Ostomy Visitation Program which is sponsored by the Cancer Society. Booklets were distributed and ostomy equipment was demonstrated. Mrs. Jones stressed rehabilitation service and asked the doctors to refer ostomy patients to the club for membership and assistance.

The West Virginia Medical Institute was discussed and application blanks were distributed.

The Society approved sending *The West Virginia Medical Journal* to students from Mercer County who are attending the West Virginia University School of Medicine.—John J. Mahood, M. D., Secretary.

MONONGALIA

Dr. Irving Kushner presented the scientific program at the meeting of the Monongalia County Medical Society on January 8 at the Old Mill Club in Morgantown. Doctor Kushner, Professor of Medicine and Chairman of the Division of Rheumatology at the West Virginia University School of Medicine, spoke on "The Management of Rheumatoid Arthritis."

The Society again voted to provide subscriptions to *The West Virginia Medical Journal* for students at the WVU Medical Center who come from Monongalia County.

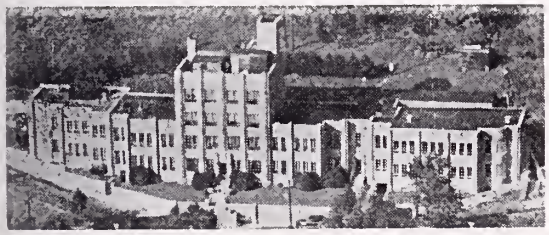
Dr. C. A. Logue of Morgantown volunteered to attend the AMA National Leadership Conference on January 25 in Chicago.—H. Summers Harrison, M. D., Secretary.

Application Deadline June 15 For FP Board Exam

A deadline of June 15 has been announced for submitting applications for the next certification examination of the American Board of Family Practice.

The next two-day written examination will be given October 19-20. It will be held in five centers geographically distributed throughout the United States.

Information regarding the examination may be obtained by writing: Nicholas J. Pisacano, M. D., Secretary, American Board of Family Practice, Inc., University of Kentucky Medical Center, Annex #2, Room 229, Lexington, Kentucky 40506. Completed applications also should be sent to this address.



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Book Reviews

YOUR PERSONAL LEARNING PLAN — Published by the Illinois Council on Continuing Medical Education, 360 North Michigan Avenue, Chicago, Illinois 60601. 1973. Pp 32. Price $1.

The pamphlet outlines the elements of a good plan for future education. It informs you on how to determine your needs and assess your own practice.

It is a well-planned procedure for self determination of knowledge and will indicate the gaps where special training is indicated. For success, the plan must be followed carefully and continued indefinitely. It is worth a try.

* * * *

THE DIABETIC FOOT—By Marvin E. Levin, M. D., Assistant Professor of Clinical Medicine, Washington University School of Medicine; Associate Attending Physician, Jewish Hospital, St. Louis, Missouri; and Lawrence W. O'Neal, M. D., Associate Professor of Clinical Surgery, Washington University School of Medicine, St. Louis, Missouri. The C. V. Mosby Company, 11830 Westline Industrial Drive, St. Louis, Missouri 63141. 1973. 262 Pages with 249 illustrations. Price $25.50.

This small volume, 262 pages, is filled with current information, excellent pictures, and advice on how to manage the various complications which the diabetic and the physician may face during the course of this chronic disease.

Although it is edited by these two men and the contributors consist of 12 or 13 physicians and surgeons, it seems to be very well done, and it is in enough detail to be of assistance to the man in his office or for the surgeon preparing for one of the surgical procedures that may become needed.

The theoretical aspects are not overwhelming and the pictures and tables, in my opinion, are excellent. This is a book that general surgeons, orthopedists and vascular surgeons as well as the diabetic specialist would find very useful on their shelves. The hospital library would be encouraged to have the book on its shelf so that the resident may refer to it from time to time.

I believe that this small book will prove to be a very useful source of treatment reference for me and should prove of inestimable value to many practicing and teaching physicians.—Ralph H. Nestmann, M. D.

Childhood Cancer Conference In Dallas May 16-18

The American Cancer Society's National Conference on Childhood Cancer will be held May 16-18 at the Fairmont Hotel in Dallas, Texas. The purpose of this Conference is to alert the medical community to the progress being made in the diagnosis and treatment of childhood cancer and to emphasize the need for early diagnosis.

For information write: American Cancer Society's National Conference on Childhood Cancer, 219 East 42nd Street, New York, New York 10017.

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WANTED—Full-time Public Health Physician for Cabell-Huntington Health Department, Huntington, West Virginia. Opening available immediately. Contact Mr. Ernest Leaberry, President, 1336 16th Street, Huntington, W. Va. 25701.

PHYSICIAN'S PRACTICE FOR SALE — Well-equipped office of recently deceased physician is for sale and would be a most attractive opportunity for a family physician. Three treatment rooms plus a laboratory. Contact Mrs. Frank M. Muldoon, Salem, W. Va. 26426.

WANTED—Excellent opportunity for qualified obstetrician-gynecologist and pediatrican; office space, equipment, staff and excellent financial arrangements. Unlimited potential. Call Administrator "Collect" (304) 675-4340.

WANTED—A physician to take over the practice of an established physician in the community of Middlebourne and surrounding area of West Virginia. A fine opportunity with unlimited potential for an ambitious practitioner. Citizens in the area will do everything possible to help a new physician. Contact Mr. Philip B. Stealey, Secretary, Middlebourne Lions Club, Middlebourne, W. Va. 26149.

PHYSICIAN WANTED—An experienced practitioner to add to and work with an established group in Charleston. Excellent working conditions with regular hours and minimal night work. Liberal vacation, sick leave and holiday program. Pension plan, Social Security, and professional liability insurance coverage. Apply Charles E. Staats, M. D., 123 West Washington Street, Charleston, W. Va. 25302—Telephone 346-0381 Area Code 304.

WANTED—Internist urgently needed in a growing northeastern West Virginia community; drawing area is approximately 23,000; modern hospital with excellent facilities; office space available; guaranteed annual income; centrally located for vast recreational facilities. Write RLH, The West Virginia Medical Journal, P. O. Box 1031, Charleston, W. Va. 25324.

WANTED—Two general practitioners and a pediatrician to locate in a rapidly growing and extremely progressive community; excellent recreational facilities; within driving distance of the larger metropolitan areas; modern 45-bed general hospital, fully equipped and staffed; qualified general surgeon in residence. Write HRL, The West Virginia Medical Journal, P. O. Box 1031, Charleston, W. Va. 25324.

WANTED—A physician to serve the area of Pennsboro in Ritchie County. A building to accommodate two physicians and one dentist has been completed. Citizens of Pennsboro guarantee that the physician will receive cordial reception and the area offers a wonderful opportunity for a young, ambitious physician. If interested, contact Mrs. J. Carl Rinehart, Pennsboro, W. Va.

WANTED—A general practitioner to locate in the growing town of Fort Ashby (Mineral County) West Virginia, situated to serve the communities of Short Gap, Springfield and Green Spring. Excellent opportunity for an ambitious physician. For information on possible assistance in establishing office facilities, contact Doctor Committee, Fort Ashby Lions Club, Fort Ashby, W. Va. 26719.

WANTED—Emergency room physician in a teaching hospital. May develop any weak areas if you desire. Permanent position in a city of 25,000. Safe friendly area to live and bring up children. Annuity negotiable—based on academic and practical background. Send curriculum vitae before calling. Contact L. Perry Hyde, M. D., Director, Emergency and Ambulatory Care, Beckley Appalachian Regional Hospital, Beckley, W. Va. 25801. Phone: (304) 255-3000.

WANTED—General practitioner, internist, pediatrician and emergency room physician to associate with other specialties in small town in Southern West Virginia. Accredited 82-bed hospital and new clinic building. Excellent working conditions. Short-term appointments available. Contact Jorge J. San Pedro, M.D., Man, W. Va. (304) 583-6541.

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PHYSICIANS WANTED—Due to death and retirement, general practitioners and all varieties of specialists are needed in Clarksburg area. Financial help provided. Contact Dr. Herman Fischer, Recruitment Committee Chairman, 224 W. Olive Street, Bridgeport, W. Va. 26330.

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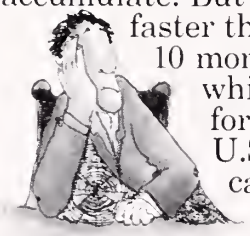

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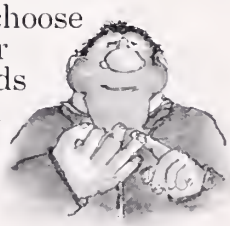

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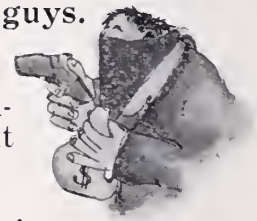

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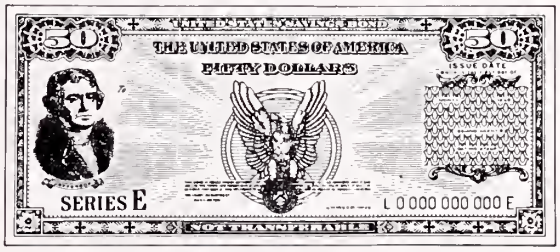

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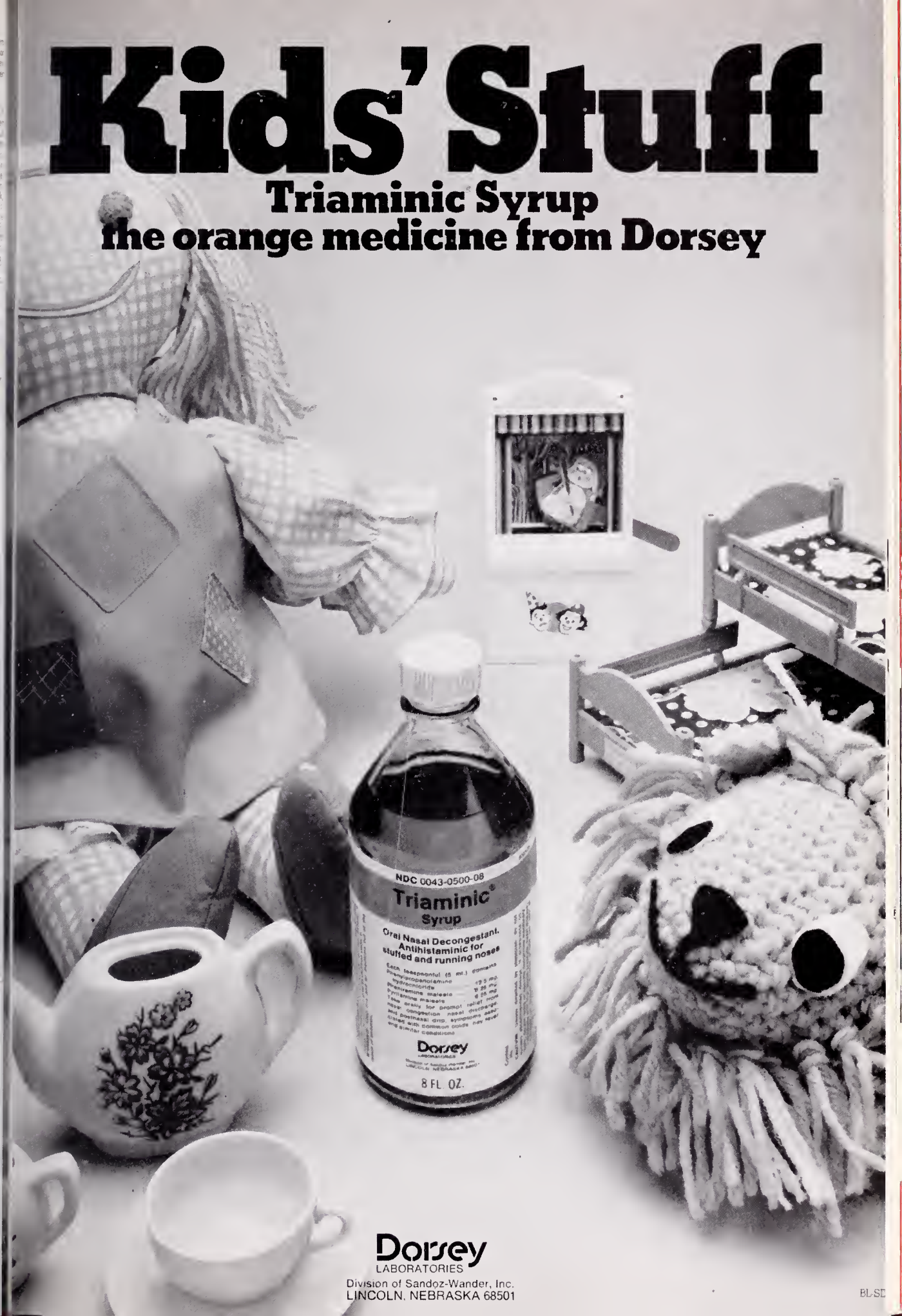

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Antiminth (pyrantel pamoate) Oral Suspension

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13μg/ml.) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 cc.)

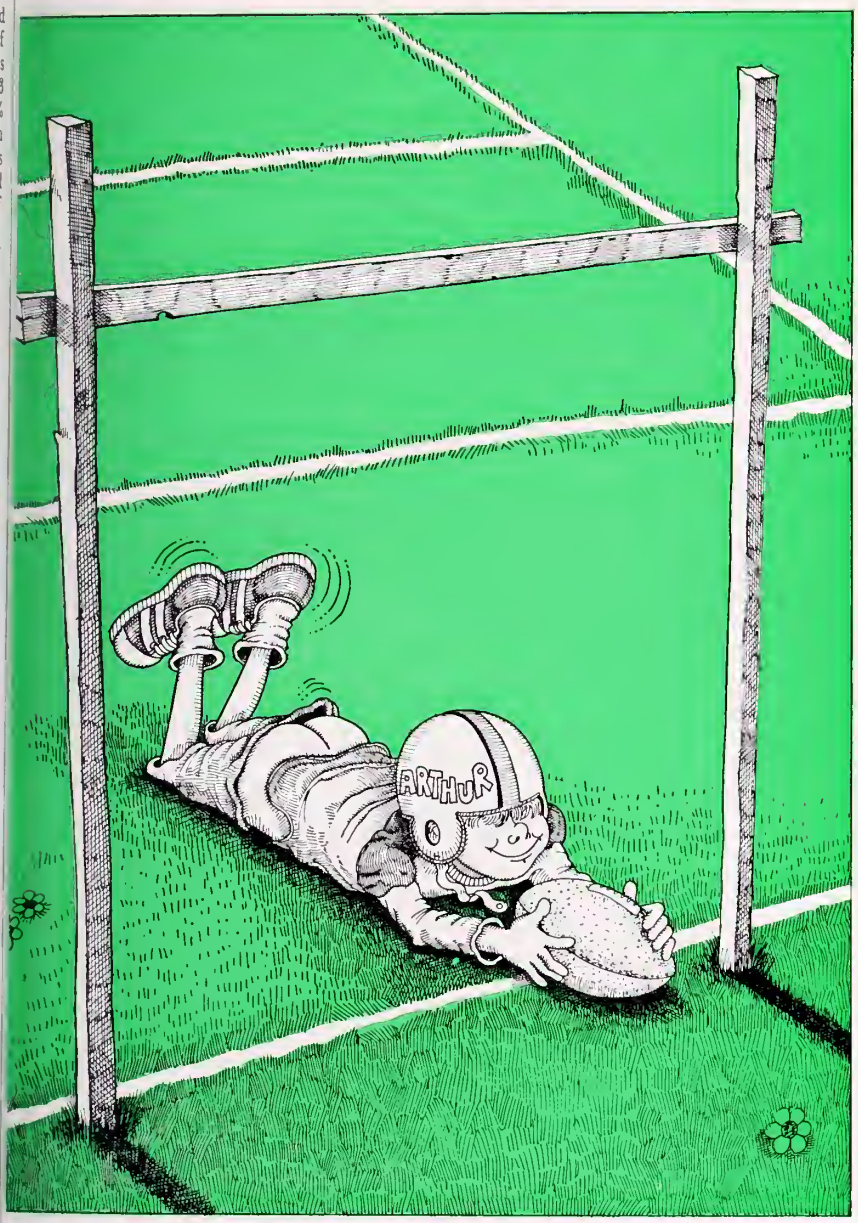
Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day; and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices. Because of limited data on repeated doses, no recommendations can be made.

How Supplied. Antiminth is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg. pyrantel base per ml., supplied in 60 cc. bottles.

ROERIG Pfizer

A division of Pfizer Pharmaceuticals
New York, New York 10017

WORMS BLITZED



A single dose of Antiminth (1 cc. per 10 lbs. of body weight, 1 tsp./50 lbs.—maximum dose, 4 tsp=20 cc.) offers highly effective control of *both* pinworms and roundworms.

Antiminth has been shown to be extremely well tolerated by children and adults alike in clinical studies.* Pleasantly caramel-flavored, it is non-staining to teeth and oral mucosa on ingestion... doesn't stain stools, linen or clothing.

One prescription can economically treat the entire family.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

Pinworms, roundworms controlled with a single, non-staining dose of

ANTIMINTH®

(pyrantel pamoate)

equivalent to 50 mg. pyrantel/ml.

ORAL SUSPENSION

a on file at Roerig.

Please see prescribing information on facing page.

With the means at hand to drastically reduce the number of deaths each year from uterine cancer, we have embarked on a nationwide, life-saving program. Its goal is a Pap test by 1976 for every woman 20 years or older to whom the test is applicable, and for younger women at risk. An ambitious program, doctor, and one which can only be realized with your help.

We are faced with these facts: only 53% of women over 20 have ever had a Pap test; only 20% get a Pap test periodically; each year about 43,000 new cases are diagnosed; this year 12,000 women in this country will die of uterine cancer. And about 75% of these deaths will result from cervical cancer—as you know, almost 100% curable when diagnosed early and treated promptly.

We hope to reach women in the target group not only with the message about the *vital* Pap test, but also with the urgency of including it in the *regular* health checkup. The mortality rate from uterine cancer could thus be dramatically curtailed.

Clearly action is called for. Coordinated action—involving the doctor, the patient, the American Cancer Society—a partnership for life.

a partnership for life

American Cancer Society

WEST VIRGINIA DIVISION, INC.
325 Professional Building
Charleston, West Virginia

THIS SPACE CONTRIBUTED BY THE PUBLISHER AS A PUBLIC SERVICE

Maybe the patient's self-diagnosis is right. He could have hay fever. But that bright red nasal mucosa, along with the thick discharge and excoriation around the nares, strongly suggests that the main problem is a cold. Hay fever or another form of allergic rhinitis may or may not be an underlying factor.

If a complete history and examination rule out allergic rhinitis, the long-term outlook will be a lot more favorable than his own "diagnosis" would have indicated.

But right now, whether he's got allergic rhinitis or a cold, he's suffering from the same irritating symptoms of drip, congestion and stuffiness. Try DIMETAPP EXTENTABS®. They're formulated to relieve these symptoms without much chance of causing drowsiness or overstimulation. Your patients will appreciate the 24-hour relief they can get from just one tablet every 12 hours.

Cold or

Allergy?

Whether it's a cold or an allergy, Dimetapp Extentabs® effectively relieve stuffiness, drip and congestion.

INDICATIONS: Dimetapp Extentabs are indicated for symptomatic relief of allergic manifestations of upper respiratory illnesses, such as the common cold, seasonal allergies, sinusitis, rhinitis, conjunctivitis and otitis. In these cases it quickly reduces inflammatory edema, nasal congestion and excessive upper respiratory secretions, thereby affording relief from nasal stuffiness and postnasal drip.

CONTRAINDICATIONS: Hypersensitivity to antihistamines of the same chemical class. Dimetapp Extentabs are contraindicated during pregnancy and in children under 12 years of age. Because of its drying and thickening effect on the lower respiratory secretions Dimetapp is not recommended in the treatment of bronchial asthma. Also, Dimetapp Extentabs are contraindicated in concurrent MAO inhibitor therapy.

WARNINGS: *Use in children:* In infants and children particularly, antihistamines in overdosage may produce convulsions and death.

PRECAUTIONS: Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. Until the patient's response has been determined, he should be cautioned against engaging in operations requiring alertness such as driving an automobile, operating machinery, etc. Patients receiving antihistamines should be warned against possible additive effects with CNS depressants such as alcohol, hypnotics, sedative-tranquilizers, etc.

ADVERSE REACTIONS: Adverse reactions to Dimetapp Extentabs may include hypersensitivity reactions such as rash, urticaria, leukopenia, agranulocytosis, and thrombocytopenia; drowsiness, lassitude, giddiness, dryness of the mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, hypotension/hypertension, headache, faintness, dizziness, tinnitus, incoordination, visual disturbances, mydriasis, CNS-depressant and (less often) stimulant effect, anorexia, nausea, vomiting, diarrhea, constipation, and epigastric distress.

HOW SUPPLIED: Light blue Extentabs in bottles of 100 and 500.

Dimetapp Extentabs®

Dimetane® (brompheniramine maleate), 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.

A·H·ROBINS

A. H. Robins Company, Richmond, Va. 23220

when pain goes on... and on... and on–

For the patient with a terminal illness, PAIN past, present, and future can dominate his thoughts until it becomes almost an obsession. The more he is aware of the pain he is now experiencing, the more difficult it is to erase his memory of yesterday's pain, and to allay his fearful anticipation of tomorrow's pain.

Surely the last thing this patient needs is an analgesic containing caffeine to stimulate the senses and heighten pain awareness. A far more logical choice is Phenaphen with Codeine. The sensible formula provides ¼ grain of phenobarbital to take the nervous "edge" off, so the rest of the formula can help control the pain more effectively. Don't you agree, Doctor, that psychic distress is an important factor in most of your terminal and long-term convalescent patients?

the analgesic formula that calms instead of caffeinates

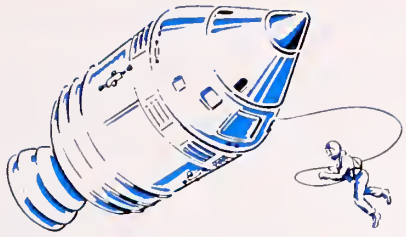
Phenaphen® with Codeine

Phenaphen with Codeine No. 2, 3, or 4 contains: Phenobarbital (¼ gr.), 16.2 mg. (warning: may be habit forming); Aspirin (2½ gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Codeine phosphate, ¼ gr. (No. 2), ½ gr. (No. 3) or 1 gr. (No. 4) (warning: may be habit forming).

Indications: Provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products, excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** Phenaphen No. 2 and No. 3—1 or 2 capsules every 3 to 4 hours as needed; Phenaphen No. 4—1 capsule every 3 to 4 hours as needed. For further details see product literature.

(III) Phenaphen with Codeine is now classified in Schedule III, Controlled Substances Act of 1970. Available on written or oral prescription and may be refilled 5 times within 6 months, unless restricted by state law.

A. H. Robins Company, Richmond, Va. A·H·ROBINS



Man in space, now fait accompli, re-emphasizes the importance of Uro-Phosphate therapy. Research into the effect of space travel on the astronaut reveals that weightlessness causes loss of bone calcium. As the bones are required to bear less and less of the weight of the body they lose calcium, increasing the calcium content of the urine. When physical activity is reduced, the acidity of the urine should be adjusted to keep increased calcium in solution . . . . a prophylaxis to prevent kidney or bladder calculi.

Uro-Phosphate®

NOW A SUGAR-COATED TABLET

Each tablet contains: METHENAMINE, *300 mg.;* SODIUM ACID PHOSPHATE, *500 mg.*

Uro-Phosphate gives comfort and protection when inactivity causes discomfort in the urinary function. It keeps calcium in solution, preventing calculi; it maintains clear, acid, sterile urine; it encourages complete voiding and lessens frequency when residual urine is present.

Dosage:

For protection of the inactive patient 1 or 2 tablets every 4 to 6 hours is usually sufficient to keep the urine clear, acid and sterile.

2 tablets on retiring will keep residual urine acid and sterile, contributing to comfort and rest.

A clinical supply will be sent to physicians and hospitals on request.

Uro-Phosphate contains sodium acid phosphate, a natural urinary acidifier. This component is fortified with methenamine which is inert until it reaches the acid urinary bladder. In this environment it releases a mild antiseptic keeping the urine sterile.

Uro-Phosphate is safe for continuous use. There are no contra-indications other than acidosis. It can be given in sufficient amount to keep the urine clear, acid and sterile. A heavy sugar coating protects its potency.

WILLIAM P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA 23217

Manufacturers of Ethical Pharmaceuticals

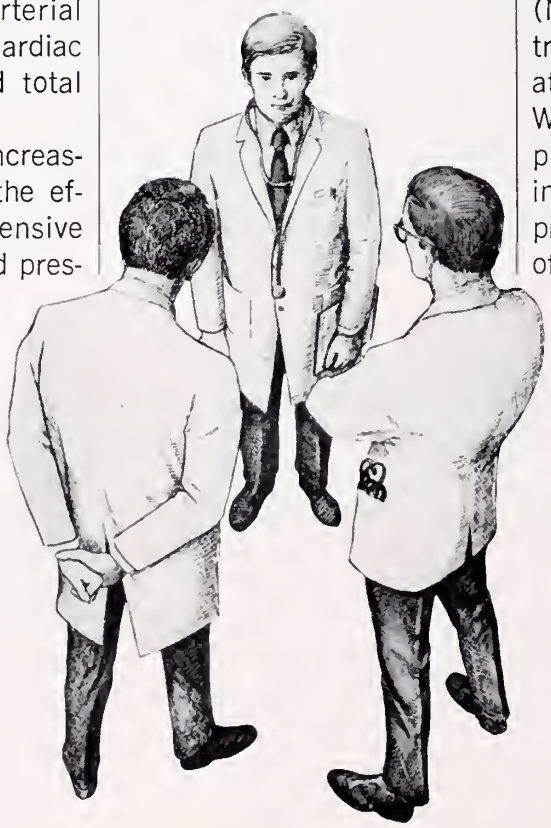
The more physicians consider the hemodynamics of lowering blood pressure...

Most physicians now agree on the importance of reducing blood pressure in the hypertensive patient. But high blood pressure exists, of course, only as part of a complete clinical picture. The hemodynamic profile of well-established essential hypertension is characterized by elevated arterial blood pressure, normal cardiac output, and increased total peripheral resistance.

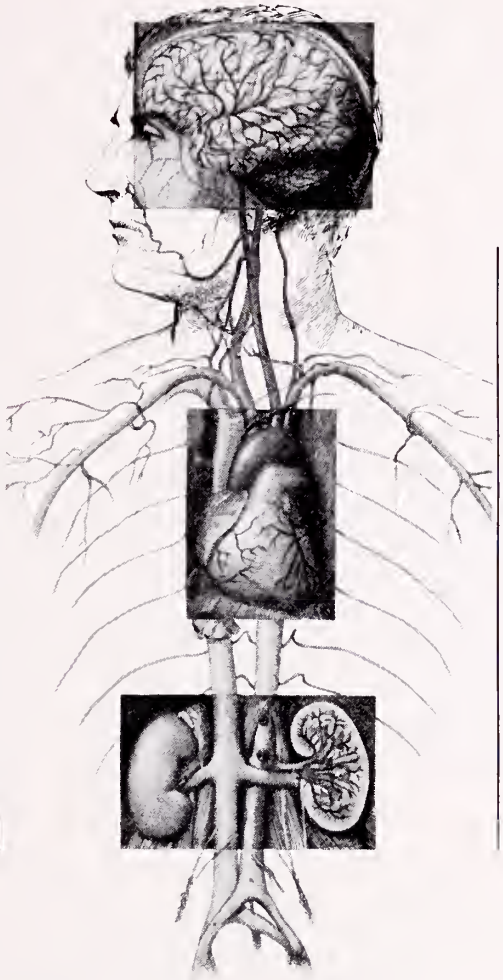
And so, physicians are increasingly concerned with the effects of an antihypertensive agent not only on blood pressure itself but also on the hemodynamic pattern—in short, with the total effect of the drug. *Does* it indeed help lower blood pressure effectively? *Is* peripheral resistance reduced? *Are* cardiac output and renal functions maintained? And, also, is there likely to be drug-induced postural hypotension serious enough to pose a threat to the patient's cerebrovascular status?

With this emphasis on overall drug performance has come a growing reliance on ALDOMET® (Methyldopa, MSD) in the treatment of sustained moderate hypertension.

With its unique hemodynamic profile, ALDOMET has drawn increasing attention and approval from physicians. First, of course, for its efficacy in



the more physicians rely on this unique antihypertensive



owering blood pressure. But here are other considerations as well. Cardiac output is usually maintained with no cardiac acceleration; in some patients the heart rate is actually slowed. Peripheral resistance is apparently reduced. ALDOMET does not usually compromise existing renal function; it generally does not reduce renal blood flow, glomerular filtration rate, or filtration fraction. And ALDOMET usually does not cause symptomatic postural or exercise hypotension.

Some patients on continuous methyldopa therapy may develop a positive direct Coombs test. For more details, see the brief summary of prescribing information.

Contraindicated in active hepatic disease and known sensitivity to the drug. Not recommended in pheochromocytoma or pregnancy. It should be used with caution in patients with a history of liver disease or dysfunction. Discontinue the drug if fever, abnormal liver function, jaundice, or acquired hemolytic anemia occurs.

In most cases of sustained moderate hypertension

TABLETS, 250 mg

ALDOMET®

(METHYLDOPA | MSD)

smoothly lowers blood pressure

For a brief summary of prescribing information, please see following page.

In most cases of sustained moderate hypertension

TABLETS, 250 mg

ALDOMET®
(METHYLDOPA MSD)

smoothly lowers blood pressure

Contraindications: Active hepatic disease, such as acute hepatitis and active cirrhosis; known sensitivity. Not recommended in pheochromocytoma. Unsuitable in mild or labile hypertension responsive to mild sedation or thiazide therapy. Use cautiously in patients with history of previous liver disease or dysfunction.

Warnings: Acquired hemolytic anemia has occurred rarely in association with therapy with methyldopa. Should clinical symptoms indicate the possibility of anemia, hemoglobin and/or hematocrit determinations should be performed. If anemia is present, appropriate laboratory studies should be done to determine if hemolysis is present. Evidence of hemolytic anemia is an indication for discontinuation of the drug. Discontinuation of methyldopa alone or the initiation of adrenocortical steroids usually results in a prompt remission of the anemia. Rarely, however, fatalities have occurred.

Some patients on continued therapy with methyldopa develop a positive direct Coombs test; incidence reported has averaged between 10% and 20%. It rarely occurs in first six months of therapy, and if not seen within twelve months, is unlikely to develop with continued administration. Positive Coombs test is dose-related; lowest incidence occurs in patients on 1 g methyldopa or less per day. Reversal of the positive Coombs test occurs within weeks to months after discontinuation of methyldopa. Prior knowledge of a positive Coombs reaction aids in evaluation of cross match for transfusions. Patients with positive Coombs tests at time of cross match may exhibit incompatible minor cross match. When this occurs, an indirect Coombs test should be performed. If negative, transfusion with blood otherwise compatible in the major cross match may be carried out. If positive, advisability of transfusion with blood compatible in major cross match should be determined by hematologist or expert in transfusion problems.

Fever has occurred within first three weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first two to three months of therapy. Rare cases of fatal hepatic necrosis have been reported. Liver biopsy in several patients with liver dysfunction has shown microscopic focal necrosis compatible with drug hypersensitivity. Rarely, reversible reduction in leukocyte count with primary effect on granulocytes has been seen; reversible agranulocytosis has been reported. Methyldopa may interfere with measurement of creatinine by alkaline picrate method and of uric acid by phosphotungstate method. When used with other antihypertensive drugs, potentiation of antihypertensive action may occur.

Usage in Pregnancy and Childbearing Age—Not recommended in pregnancy. In women of childbearing age, weigh potential benefits against possible fetal hazards.

Precautions: Perform periodic hepatic function tests and white cell and differential blood counts during first six to twelve weeks of therapy or in unexplained fever. Discontinue if fever, abnormalities in liver function tests, or jaundice appears. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, spuriously high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. Discontinue drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Anesthetics requirements may be reduced; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension may occur after dialysis because methyldopa is removed by this procedure.

Dosage should be limited initially to 500 mg daily when following previous antihypertensive agents other than thiazides. Do not exceed recommended daily dose of 3.0 g. Patients with impaired renal function may respond to smaller doses than patients with normal kidney function. Syncope in older patients has been related to increased sensitivity in those with advanced arteriosclerotic vascular disease; this may be avoided by lower doses. Tolerance occasionally seen either early or late, but more likely between second and third month after initiation of therapy; increased dosage or combined therapy with a thiazide frequently restores effective control.

Adverse Reactions: Sedation, usually transient, may be seen during initial therapy or when dosage is increased. Headache, asthenia, or weakness may be noted as early, transient symptoms. Symptoms associated with effective lowering of blood pressure, including dizziness, lightheadedness, and symptoms of cerebrovascular insufficiency, are seen occasionally. Angina pectoris may be aggravated. Symptoms of orthostatic and exercise hypotension may occur; if symptoms occur, reduce dosage. Bradycardia, nasal stuffiness, mild dryness of mouth, and gastrointestinal symptoms including distension, constipation, flatus, and diarrhea occur occasionally; these can be relieved by reducing dosage. Nausea and vomiting have been reported in only a few patients. Sore tongue or "black tongue," pancreatitis, and inflammation of salivary glands may occur.

Weight gain and edema occur infrequently; if edema progresses or signs of pulmonary congestion appear, discontinue drug. Rarely, urine exposed to air may darken due to breakdown of methyldopa or its metabolites. Other rare reactions include breast enlargement, lactation, impotence, decreased libido, skin rash, mild arthralgia, myalgia, paresthesias, parkinsonism, psychic disturbances including nightmares, reversible mild psychoses or depression, reversible thrombocytopenia, drug-related fever and abnormal liver function studies with jaundice and hepatocellular damage (see **Warnings** and **Precautions**), rise in BUN, and a single case of bilateral Bell's palsy.

Supplied: Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

ADDENDU

MS
MEF
SHA
DOH

Let's make blood pressure "required reading" for all physicians.

With recent estimates that abou 23 million Americans have high blood pressure—and that half of them are not even aware of it—detection of the problem in asymptomatic persons has become an issue of national importance.

Family physicians are being urged to take blood pressure readings as a matter of office routine, regardless of the presenting complaint or the reason for the visit. And because many people do not see a family physician for relatively long periods of time, some experts are suggesting that ophthalmolo gists, gynecologists, dermatologists, orthopedists, psychiatrists, dentists, school nurses, family planning counselors, and other health-care personnel make blood pressure reading a routine part of every examination or consultation.

Of course, a diagnosis of hypertension cannot be made on the basis of a single reading, but routine blood pressure readings can uncover potential trouble in a certain proportion of patients. And when trouble is suggested, further evaluation can be pursued more effectively.

Blood pressure—"required reading" for all physicians.

efore prescribing, see complete prescribing formation in SK&F literature or *PDR*. The llowing is a brief summary.

dications: Edema associated with congestive eart failure, cirrhosis of the liver, the nephrotic ndrome; steroid-induced and idiopathic lema; edema resistant to other diuretic therapy. lso, mild to moderate hypertension.

ontraindications: Pre-existing elevated serum otassium. Hypersensitivity to either component. Continued use in progressive renal or epatic dysfunction or developing hyperkalemia.

/arnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia evelops or dietary potassium intake is markedly npaired. Enteric-coated potassium salts may ause small bowel stenosis with or without lceration. Hyperkalemia (>5.4 mEq/L) has een reported in 4% of patients under 60 years, 1 12% of patients over 60 years, and in less han 8% of patients overall. Rarely, cases have een associated with cardiac irregularities. **ccordingly, check serum potassium during herapy, particularly in patients with suspected r confirmed renal insufficiency (e.g., elderly or liabetics). If hyperkalemia develops, substitute thiazide alone. If spironolactone is used oncomitantly with 'Dyazide', check serum otassium frequently**—both can cause potassium etention and sometimes hyperkalemia. Two leaths have been reported in patients on such ombined therapy (in one, recommended losage was exceeded; in the other, serum electrolytes were not properly monitored). Observe atients on 'Dyazide' regularly for possible lood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been eported in patients receiving Dyrenium triamterene, SK&F). Rarely, leukopenia, hrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ll cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, descreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

Supplied: Bottles and Single Unit Packages of 100 capsules.

SK&F CO.
Carolina, P.R. 00630
Subsidiary of SmithKline Corp.

WHEN YOUR DIGITALIZED PATIENT NEEDS A DIURETIC, SHE NEEDS DYAZIDE®

- relieves edema*
- conserves potassium
- reduces the risk of digitalis intoxication due to potassium depletion. Potassium depletion sensitizes the myocardium to the toxic effects of digitalis, and reduces its inotropic effect.

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DYAZIDE®

Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

MEETS THE HEARTFELT NEED OF THE DIGITALIZED PATIENT

The Weight of Professional Opinion

It's time for action to defend the laws and regulations that protect your patients against drug substitution.

These professional and trade organizations are united in supporting antisubstitution statutes and regulations:

The American Academy of Dermatolog

The Board of Directors of the American Academy of Family Physicians

The Executive Board of the American Academy of Neurology

The Committee on Drugs of the American Academy of Pediatrics

The American College of Allergists

The Executive Committee of the American College of Obstetricians and Gynecologists

The Board of Regents of the American College of Physicians

The Board of Trustees of the American Dental Association

The Board of Trustees of the American Medical Association

The American Psychiatric Associatic

The Executive Committee of the National Association of Retail Druggists

The Board of Directors of the Pharmaceutical Manufacturers Association

The National Wholesale Druggists' Association

Joint Statement on Antisubstitution Laws and Regulations

The purpose of this statement is to affirm the support of the participating organizations for the laws, regulations and professional traditions which prohibit the unauthorized substitution of drug products.

Traditionally, physicians, dentists and pharmacists have worked cooperatively to serve the best interests of patients. Productive cooperation has been achieved through mutual respect as well as a common concern for the ideals of public service. This mutual respect has been reflected, in part, by joint support over the years for the adoption and enforcement of laws and regulations specifically prohibiting unauthorized substitution and encouraging joint discussion and selection of the source of supply of drug products. The basic principles of medical, dental and pharmacy practice are thus utilized and preserved in the interest of patient welfare.

The antisubstitution laws have not obstructed enhancement of the professional status of pharmacy any more than they have in and of themselves guaranteed absolute protection from unsafe drugs, or freed physicians, dentists and pharmacists from their responsibilities to patients. As a practical matter, however, such laws and regulations encourage interprofessional communications regarding drug product selection and assure each profession the opportunity to exercise fully its expertise in drug usage, to the advantage of patients.

Physicians and dentists should be urged to increase the frequency and regularity of their contacts with pharmacists in selection of quality drug products, recognizing that economies to patients can be improved through such communication, taking into account the patients' needs. The pharmacist's knowledge of the chemical characteristics of drugs, their mode of action, toxic properties and other characteristics that assist in making drug selection decisions should be utilized to the fullest extent practicable by physicians and dentists in serving their patients.

Since drug product selection entails knowledge derived from clinical experience, the physician's and dentist's roles in product selection remain primary and do not permit delegation of decisions requiring medical and dental judgments. A broader role in therapy will evolve for pharmacists as improved understanding and cooperation among the professions continue to grow.

There has been no evidence that there are convincing reasons to modify or repeal existing laws and regulations prohibiting the unauthorized substitution of another drug product for the one specified by a prescriber. It is our belief that such laws and regulations merit the joint support of the medical, dental and pharmaceutical professions and the pharmaceutical industry.

Add your opinion to the weight of other professionals and send it to your state assemblyman or legislator.

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D. C. 20005

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new

DARVOCET-N®

50 mg. propoxyphene napsylate
and 325 mg. acetaminophen

Lilly

TABLETS

Additional information available to the profession on request.
Eli Lilly and Company, Indianapolis, Indiana 46206

300104

The West Virginia Medical Journal

Vol. 70, No. 4 April, 1974

Acute Volvulus Of The Sigmoid Colon In A Two-Year-Old Child*

T. H. Chang, M. D.

Volvulus of the sigmoid colon is a well-defined abdominal condition. It has been considered to be a disease of the elderly; quite rarely, however, it is encountered in children. When it occurs in the young it usually is acute and fulminating. There had been few reports of acute sigmoid volvulus in children until Carter and Hinshaw[1] reported two cases in 1960. Since that time several additional cases have been reported by Allen, Lillard, Myers and Hunter.[2,4,5,8] While the condition in adults usually is found in cold countries such as Northern Russia, Finland and the mountainous districts of Yugoslavia, this predilection does not seem to apply to acute volvulus in children.

The purpose of this paper is to report a case of acute sigmoid volvulus in a two-year old and to review briefly the pathophysiology, diagnosis and management of acute volvulus of the sigmoid colon.

Pathophysiology

In order to appreciate the problems involved in the diagnosis and management of acute sigmoid volvulus, it is necessary to understand the pathophysiology of this acute abdominal condition. It has been shown that both congenital and acquired factors are etiologically significant. The most important one is a redundant, large sigmoid loop with a short mesenteric base. In addition to the congenital factor the secondary contraction of the base of the mesentery is a significant factor to cause sigmoid volvulus,[9] while in adults a fecal mass in the left colon is known to be a significant secondary factor to initiate sigmoid twist. In Northern countries, in below zero weather, it is understandable that visits to outside latrines are reduced and subsequently a large fecal mass accumulates in the left colon. The same effect occurs in catatonic schizophrenic patients who notoriously disregard the calls of nature.

In sigmoid volvulus the twist usually occurs in a counterclockwise direction around the axis of its mesentery, accompanied by torsion of the axis of the bowel.

Moderate torsion of the sigmoid produces a simple obstruction without strangulation. After a varying time necrotic changes may occur in the bowel wall at the site of the torsion if the condition is not relieved. A torsion of 360° or more almost invariably causes strangulation. Sigmoid volvulus basically causes a closed loop obstruction between the proximal and distal points of the involved bowel. It also may be complicated by a second closed loop obstruction occurring between the point of the sigmoid torsion and a competent ileocecal valve.[9,10]

Symptoms and Findings

The principal symptoms of sigmoid volvulus are abdominal distention and cramping type of abdominal pain. Hinshaw and Carter[1] first noted that sigmoid volvulus in children tends to occur in an acute fulminating form with a sudden onset, rapid course and early bowel necrosis. This

The Author

- **T. H. Chang, M. D., The Myers Clinic and Broaddus Hospital, Philippi, West Virginia.**

*Presented during the Spring Meeting of the West Virginia Chapter, American College of Surgeons, May 3-5, 1973, at The Greenbrier, White Sulphur Springs, West Virginia.

Figure 1 (Left). A restrospective review of an upright abdominal roentgenogram demonstrates a gas-filled loop of bowel in the left upper quadrant showing typical "Omega loop" appearance. Figure 2 (Right). Upright abdominal roentgenogram demonstrates a gas-filled, closed loop of the colon in the left upper quadrant, showing typical "bent-inner tube" appearance.

Figure 3 (Left). Another upright abdominal roentgenogram shows a second closed loop obstruction in the right upper quadrant. Figure 4 (Right). Barium enema demonstrates spiral twists at the rectosigmoid junction and above this, a distended redundant loop of sigmoid colon with an appearance of obstruction without spill.

is in contrast to the subacute form which usually occurs in older patients. The patient usually has a history of repeated attacks of abdominal cramps and distention. If marked tenderness and muscular rigidity of the abdominal wall are present, strangulation or peritonitis should be suspected. Rectal examination usually reveals an empty rectum. Fever and marked leukocytosis suggest strangulation or peritonitis.

Diagnosis

The diagnosis of sigmoid volvulus usually is confirmed by a flat film of the abdomen. Characteristically there is a huge amount of gaseous distention, a single colonic loop extending upward from the pelvis frequently to the diaphragm, giving the general appearance of a "bent inner tube," a "large horseshoe" or an "Omega loop."

With progression of the disease, distention of the proximal colon occurs and results in the production of many dilated loops of colon and distal ileum. If the ileocecal valve is competent, the second closed loop which is produced may be demonstrated in the roentgenograms on the right side of the abdomen.

In difficult diagnostic problem cases a barium enema is advisable. The study may reveal a typical "bird's beak" (without spill) or if the barium spills an "ace of spades" appearance with spiral narrowing of the proximal end of the distal segment.

Proctoscopic examination may reveal the spiral folds of the twisted mucosa and may reveal gangrenous discoloration of the mucosa if there is strangulation.

Management

There has been considerable controversy about the management of acute sigmoid volvulus. Often hydrostatic reduction may occur at the time of the diagnostic barium enema examination in children.[2] While Bruusgaard[3] has advocated passing a rectal tube through the sigmoid twist under sigmoidoscopic control in adults, this method is not advisable in children for the following reasons: (1) It is difficult to know whether or not ischemic bowel is present; (2) It is never a definitive form of treatment; and (3) Sigmoid volvulus is known to be a recurrent condition.[1] Resection is always the treatment of choice in the young since there is no means for adequate fixation of the redundant sigmoid colon and any procedure short of resection may result in recurrence, gangrene and perforation. At the operation, if the bowel is not compromised by excessive edema or ischemia, primary resection of the diseased loop with immediate anastomosis should be carried out. When gangrenous bowel is suspected, however, exteriorization or obstructive excision should be carried out.

Figure 5 (Left). After spontaneous reduction of sigmoid volvulous, barium enema revealed marked redundant sigmoid colon. Figure 6 (Right). Recent follow-up barium enema showing a normally functioning colon.

Report of a Case

A two-year-old, Caucasian boy was admitted to Broaddus Hospital in March 1972 because of acute onset of abdominal distention, lower abdominal pain and vomiting of one day's duration. The family stated that approximately four months prior to this admission similar symptoms developed when the patient had an acute upper respiratory infection (Figure 1). The condition suddenly improved spontaneously at maximal distention when he expelled profuse amounts of flatus. There was nothing unusual in his dietary history and there had been no previous operations.

Physical examination revealed a well-developed, alert, well-nourished but moderately dehydrated and acutely ill boy of two years. The blood pressure was 100/60; temperature was 99.8 F. and the pulse was 100 per minute and regular. Respiratory rate was 22 per minute. The head, eyes, ears and nose were unremarkable. The throat was slightly congested. The lungs were clear and the heart was normal in size, with regular rhythm and with no audible murmurs. The abdomen was markedly distended with high-pitched, tinkling bowel sounds. There was moderate tenderness in the left lower quadrant. Rectal examination was within normal limits.

Laboratory studies included hemoglobin which was 14 Gm., WBC 8800 with 15 per cent polymorphonuclear neutrophils, 72 per cent lymphocytes. Urinalysis was negative. Serum electrolyte studies revealed that the $Na+$ was 139 mEq./L, Cl^- was 96 mEq./L, $K+$ was 4.2 mEq./L, HCo_3^- was 27 mEq./L. Supine and upright abdominal roentgenograms revealed a gas-filled, closed loop of the colon in the left upper quadrant and it demonstrated typical "bent inner tube" or "Omega loop" appearance (Figure 2). In the right upper quadrant there was another gas-filled closed loop which was assumed to be located between the point where the sigmoid volvulus tapered the transverse colon and the competent ileocecal valve (Figure 3). Barium enema study showed spiral twists in the sigmoid and the distal portion of the descending colon, with an appearance of obstruction without spill and a modified "bird's beak" appearance (Figure 4).

An emergency laparotomy was scheduled but while the patient was being prepared for surgery, and crying during this time, he suddenly expelled profuse amounts of gas and liquid through the rectum and the symptoms completely subsided. The operation was temporarily canceled. Barium enema study revealed markedly redundant left-sided colon (Figure 5).

On the following day, marked abdominal distention again developed and an immediate emergency laparotomy was carried out. At operation, a distended, redundant, somewhat congested but viable sigmoid colon was found, with its base involved in a spiral twist. When the volvulus was released the sigmoid colon measured approximately 40 cm. from the peritoneal reflexion to the proximal junction of the sigmoid and the descending colon. The root of the mesentery of the colon was narrow and contained several enlarged lymph nodes. Resection of the sigmoid with primary anastomosis and tube cecostomy was carried out.

The postoperative course was uneventful and the patient has remained completely asymptomatic to date. A recent follow-up barium enema study showed a normally functioning colon (Figure 6).

Comment

This report presents a fairly rare case of sigmoid volvulus which is typical of this disease in children. The patient had repeated episodes of marked abdominal distention whenever acute respiratory infections developed. At operation marked mesenteric lymphadenopathy was found. It is, therefore, reasonable to assume that the basic congenital etiologic elements, redundant colonic loop and a short mesenteric lymphadenopathy plus a distended sigmoid, caused the sigmoid twist.

Roentgenographic findings were typical, showing a "bent inner tube" appearance in the scout films of the abdomen and the "bird's beak" appearance in the barium enema study.

In regard to management of the case, perhaps the exploratory laparotomy should have been carried out even at the time the volvulus was spontaneously released. There are those who advocate reducing the volvulus sigmoidoscopically and then performing elective resection. At operation, excision and immediate anastomosis were carried out instead of exteriorization since there was no evidence of edema or ischemia of the bowel wall. Tube cecostomy was added to the procedure because there was a second closed loop obstruction caused by a competent ileocecal valve.

Summary

1. Sigmoid volvulus in children is rare and usually is acute and fulminating in type.

2. A case of acute sigmoid volvulus in a two-year-old boy is reported. It was noted that the patient had had repeated sigmoid volvulus when-

ever lymphocytosis with lymphadenopathy occurred.

3. Congenital and acquired eitologic factors and pathophysiology of acute sigmoid volvulus in children are discussed.

4. Various roentgenologic findings are presented.

5. Resection is the treatment of choice in this condition.

A list of references may be obtained by writing The Journal.

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The Problem Of Carcinoma Of The Vermiform Appendix

Review Of Literature Proposals For Use Of New Diagnostic Techniques

(Case Report*)

Vasilios P. Dross, M. D.; and Roland W. Hipsley, M. D.

Adenocarcinoma of the appendix is a rare site of malignancy in the gastrointestinal tract. Its early detection is of primary importance because of its tendency to spread by direct extension and to invade the regional lymph nodes and veins. If it originates at the proximal portion of the appendix, it may develop as an obstructive type of a suppurative appendicitis which will alert the clinician and set in motion an emergency appendectomy revealing the primary lesion histologically. But, in the event it originates from an appendiceal polyp distally, the only symptom may be a localized mass or a gastrointestinal discomfort or both. Weight loss and melena may be noted by the examining physician which may be eventually the signs of extension and/or liver metastasis.

Since 25 per cent of appendices are located retrocecally, this event will further complicate the possibility of an early diagnosis for the unfortunate patient since the symptoms will be masked in the retroperitoneal space.

Other malignant lesions of the appendix are more or less frequently encountered. The villous adenoma is extremely rare because it usually is located in the rectosigmoid region of the G.I. tract and about 60 per cent develop adenocarcinoma of the colonic type. The carcinoid tumors which comprise about 90 per cent of the neoplasms of the appendix have their characteristic clinical syndrome if the liver is involved. The malignant mucocele of the appendix is less frequent and has its characteristic appearance during surgery when dilated or ruptured; whenever ruptured it is embedded in a gelatinous mucoid material engulfing the appendix within the entire mass with possible peritoneal dissemination involving also the cecum and the terminal ileum.

Review of Literature

The latest large review in the English literature in 1960, done by McGregor and Associates,[1] reported 84 accumulated cases. In this review the treatment of choice was simple appendectomy for the unruptured malignant mucocele and for the colonic type of adenocarcinoma of the appendix which arises from polyps and shows no invasion of the polyp stalk; if, however, there is submucosal invasion or local extension it was agreed that a right hemicolectomy offers the best prognosis. This was the conclusion of the review of 21 cases of malignant mucoceles (of which five were ruptured) and of 63 cases of colonic type of adenocarcinoma of the appendix.

Previous reviews in the literature were the following: Uihlein and McDonald[2] reviewed in 1943, from the Mayo Clinic, 144 cases of carcinoma of the appendix covering the period from 1910 to 1941, and found that malignant tumors occurred in one and two-tenths per cent of all appendiceal specimens. Of these malignant tumors 88.2 per cent were of the carcinoid type, 8.3 per cent were of the cystic type (malignant mucoceles), and three and five tenths per cent were of the colonic type. Hilsabeck[5] and Associates reviewed in 1951, also from the Mayo Clinic, 41 cases of non-carcinoid tumors of the appendix, covering the period from 1910 to 1950, of which 29 cases were of the cystic type (malignant mucoceles) treated by simple appendectomy if intact or by right simple hemicolectomy (if ruptured or if adjacent organs were involved). The remaining 12 cases were of the colonic type which revealed cecal involvement in 33 per cent of cases. They recommended, therefore, right radical hemicolectomy in such instances and

*From the Department of Surgery, Veterans Administration Hospital, Butler, Pennsylvania.

The Authors

- **Vasilios P. Dross, M. D., Veterans Administration Hospital, Huntington, West Virginia; and Roland W. Hipsley, M. D., Veterans Administration Hospital, Butler Pennsylvania (Retired).**

simple appendectomy if the lesion was limited to the mucosa and confined to the appendix. Braasch and Vansant[3] from the Lahey Clinic reviewed in 1959, 26 cases of malignant lesions of the appendix covering the period from 1930 to 1953, and found that carcinoid tumors (19 cases) were more frequently found in the appendix and were located in 75 per cent of cases at its distal third. These tumors comprise about 88 per cent of the carcinomas of the appendix. Only 10 per cent were found at the base of the appendix. They concluded, therefore, that appendiceal obstruction with inflammation would less likely develop from this type of lesion and actually the typical involvement of the terminal ileum by this lesion would cause more often signs of partial small bowel obstruction.

Mucoceles, of which 10 per cent are malignant, comprise eight per cent of all carcinomas of the appendix and present themselves as a right lower quadrant mass and if ruptured they develop peritoneal irritation by seeding and implantation of the lesion. Adenocarcinoma of the colonic type of the appendix comprises about five-tenths per cent of all types of intestinal carcinoma and about three per cent of the malignant appendiceal lesions. About 50 per cent are located proximally and develop appendiceal obstruction with inflammation. In this review of cases only five were reported with colonic adenocarcinoma and two cases were malignant mucoceles.

Callaghan[4] and Associates, in 1962, evaluated 70 reported cases in the literature of which the majority had the appendix proper involved. Thirty-five of these cases clinically developed acute appendicitis, 10 developed chronic appendicitis, five developed a right lower quadrant mass, and the remaining 10 had no clinical symptoms. It was noted that rarely obstruction, perforation or carcinoma of the cecum was diagnosed. The usual diagnosis was acute suppurative appendicitis. The initial procedure for this diagnosis was an emergency appendectomy with subsequent high mortality indicated by five reported deaths in the immediate postoperative period out of 63 cases. They concluded that for the 42 of the 63 cases appendectomy was the procedure of choice.

In the meantime, individual case reports appeared in the literature since the 1943 review of Uihlein and McDonald;[2] they also reported five cases of colonic type of carcinoma of the appendix treated by simple appendectomy, with the exception of one case which was treated with right hemicolectomy because of involvement of the cecum. Hughes,[26] in 1951, reported a case of primary adenocarcinoma forming an appendico-ileostomy-encased mass with an ileocecal intussusception for which a right hemicolectomy was performed with postoperative complications. Clark,[6] in 1953, reported two cases of adenocarcinoma complicated by gangrenous appendicitis with perforation, treated by emergency appendectomy with an eventual good prognosis because of early removal of the tumor which was still a local lesion. Hilsabeck,[5] in 1959, reported four cases treated by appendectomy with no evidence of recurrence. Clarke,[6] in 1953, reported a case also treated by appendectomy without any recurrence. Niceberg[7] and Associates, in 1956, reported a case of mucinous adenocarcinoma which developed acute gangrenous perforated appendicitis treated by appendectomy. Incidentally, they also reviewed the literature from 1930 to 1951, and found 71 cases acceptable as adenocarcinoma of the appendix, of which 16 were carcinoma *in situ*, and concluded that appendectomy alone was an acceptable procedure of treatment for the preinvasive type and that right hemicolectomy was indicated for the invasive type of adenocarcinoma of the appendix. Braasch and Vansant,[3] in 1959, reported from the Lahey Clinic five more cases of colonic CA of the appendix among the series of tumors of the appendix which also included two malignant mucoceles and 19 carcinoid tumors. All five cases ultimately had right hemicolectomies but four patients died of postoperative complications. McGregor[1] and Associates, in 1960, reported four more cases equally treated by simple appendectomy and by partial or total right hemicolectomy, of which the patient in one case of a simple appendectomy died a year later from breast cancer. They recommend simple appendectomy with the lesion restricted to the polyp without involvement of the base of the polyp, but they also advise right hemicolectomy for lesions with evidence of submucosal invasion or local extension except in cases of widespread metastasis. Tarasidis[8] and associates, in 1962, reported two cases found among 12,497 appendectomies and recommend also right hemicolectomy as the procedure of choice after reviewing the literature of 66 reported cases which revealed a high incidence (about 75 per cent) of recurrence following simple appendectomy.

Callaghan[4] and associates, in 1962, recorded a case of recurrence eight months after appendectomy for invasive carcinoma of the distal appendix; they recommend, therefore, a second look operation six months postoperatively for the invasive type of lesions located distally which

comprise about 10 per cent of the carcinomas of the appendix.

In 1962, Dalton[9] and associates reported one case of ruptured carcinoma of the appendix which appeared preoperatively as a pelvic mass rimmed by calcium with the characteristics of a malignant mucocele which was treated by simple appendectomy without recurrence on follow-up. Watkins[10] and associates, in 1964, reported two cases of mucinous adenocarcinoma of the appendix for which a block resection was performed without any evidence of recurrence on follow-up. In 1965, Totten, Jr.,[11] and associates reported five cases of primary adenocarcinoma of the appendix, making the total of reported cases 92 at that time, and recommend right radical hemicolectomy as the treatment of choice despite the poor prognosis. Seddon,[12] in 1965, reported an adenocarcinoma of the appendix associated with multiple adenocarcinomas of the colon, this one associated also with a small carcinomatous polyp of the cecum; he also recommended right hemicolectomy. Latchis,[13] in 1966, reported one case of acute appendicitis secondary to metastatic carcinoma from a previously removed carcinoma of the breast. This comprises the fifth reported case of a total of 13 documented cases reported in the literature of metastatic carcinoma of the appendix from other primaries; approximately 30 per cent of these metastatic cases develop acute obstructive appendicitis. Steinberg,[14] in 1967, reported four cases of primary adenocarcinoma of the appendix with an excellent review of 34 cases reported in the English literature. Three of these cases had a simple appendectomy for acute appendicitis, one had primary hemicolectomy, and another had a secondary hemicolectomy as found feasible or indicated during and after the original surgical procedure. Their review of the literature indicated the rarity of this lesion for the appendix ranging from one one-hundredth to eight one-hundredths per cent. The pathological classification of the carcinoma of the appendix ranges from the carcinoid type, the cystic type (malignant mucocele), the colonic type, to the invasive and noninvasive types. Edmondson and Hobbs,[16] in 1967, reported six cases and reviewed 124 other cases recorded since 1931, and have concluded that the lesion was found more frequently in males (over 40 years of age especially in the sixth decade group); it was diagnosed preoperatively always as an acute appendicitis (never carcinoma); the treatment of choice was appendectomy with primary or secondary hemicolectomy (except for the preinvasive type which may require only a simple appendectomy). They recommend in ruptured carcinomatous appendicitis prompt right hemicolectomy as the treatment of choice with only a 30 per cent mortality rate in comparison with a simple appendectomy which carries a mortality rate of 56 per cent.

It is interesting to note that according to Bierman's [15] report, in 1968, the appendix may have an anticarcinogenic systemic and local effect on the human body. Locally produced antibodies are depleted following an appendectomy or following early fibrous obliteration of the appendix, which depletion subsequently increases the incidence of carcinoma of the colon, rectum, ovary and breast, especially in the female and in the early age groups. They note in a studied postmorten group of 1,287 consecutive and unselected cases that about 23 per cent had an appendectomy. It is well known that the frequency of appendectomies in the population at large is about 6 to 15 per cent according to the McVay report. In this postmortem group the incidence of appendectomy was found to be more frequent in cases in which the patient died from cancer in comparison with these in which death occurred from a noncancerous cause. In the cancer group 35 per cent had previous appendectomy (in the males 24.1 per cent and in the females 46 per cent) in comparison with the non-cancer group of which only 24.3 per cent had appendectomy (in the males 18 per cent and in the females 32 per cent). This observation was noted also in a studied clinical and a comparable postmortem group of cases with proven lymphomas and leukemias.

From the foregoing report, it is consequently concluded by the author of this paper that despite the varied incidence of neoplastic and inflammatory involvement of the appendix the fact that the appendix may become a site of a pathological lesion should not lead us into elective, preventive or prophylactic appendectomies at random because in man the vermiform appendix is not a degenerate functional structure but a special organ involved in the immunoglobulin-producing system and as such it may influence the development of neoplastic disease if removed unnecessarily.

Other interesting individual case reports appearing in the recent literature are the following: Reichle[17] and associates, in 1971, reported two cases and recommend right hemicolectomy in the differentiated and undifferentiated adenocarcinomas because both can metastasize through the lymphatics and the blood stream despite the fact that this occurs rarely even for the malignant mucoceles. Flint[18] and associates, in 1970, re-

ported 12 cases during the past 15 years of which 35 per cent had metastases and 50 per cent died postoperatively at an average of 14.7 months; they recommend ileocolectomy strongly for the invasive, non-metastatic adenocarcinoma and for the perforated carcinomatous appendices (whenever feasible) and they also recommend the same procedure selectively for the non-invasive adenocarcinoma despite the fact that some advocate simple appendectomy for the latter cases.

Palliative therapy such as cobalt treatment and 5 FU are recommended for metastatic disease. In 1970, Otto[19] and associates reported four additional cases and noted that 152 verified cases of primary adenocarcinoma of the vermiform appendix have been reported since the first case study in 1882. They also strongly recommend a right radical primary or secondary hemicolectomy since simple appendectomy has only about 20 per cent five-year survival rate but radical right hemicolectomy has about 66 per cent five-year survival rate. Pugeda and Hinshaw, in 1969, reported seven cases of which three were diagnosed as appendiceal abscesses, two as acute appendicitis, one as carcinoma of the cecum, and one case was not diagnosed at all. They also recommend primary or secondary hemicolectomy. Capti,[24] in 1972, reported a case which was diagnosed following appendectomy and was treated subsequently by radical right hemicolectomy and later by subtotal gastrectomy (for bleeding) and segmental resection of the ileum (for metastatic disease); the patient expired from acute renal insufficiency two weeks postoperatively; Capti recommends also radical hemicolectomy and bilateral oophorectomy (because of frequent metastases to the ovaries).

Hopkins,[25] in 1972, reported a case of adenocarcinoma arising from an appendiceal villous adenoma with regional lymph node metastasis and extension into the serosa of the ileum. This patient was explored for partial small bowel obstruction of three months' duration, at which time a chronic appendiceal abscess was grossly found. The appendix and involved portions of the ileum and mesentery were resected. About 60 per cent of villous polyps develop adenocarcinoma in the appendix which are the only four of the seven villous polyps reported in the literature.

The Problem of Diagnosis

Early detection of carcinoma of the appendix remains a clinical challenge since 70 per cent are detected following appendectomy for acute suppurative appendicitis, which leaves 30 per cent

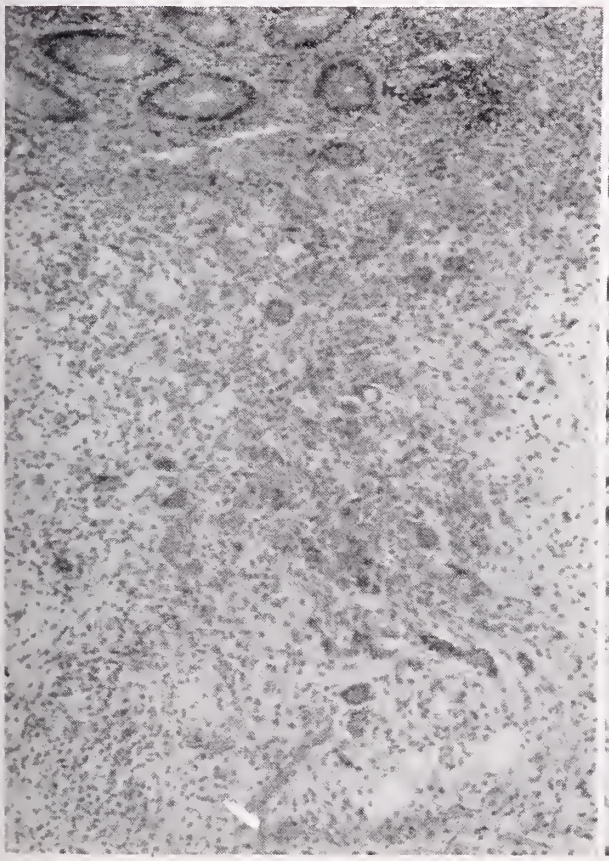


Figure 1.

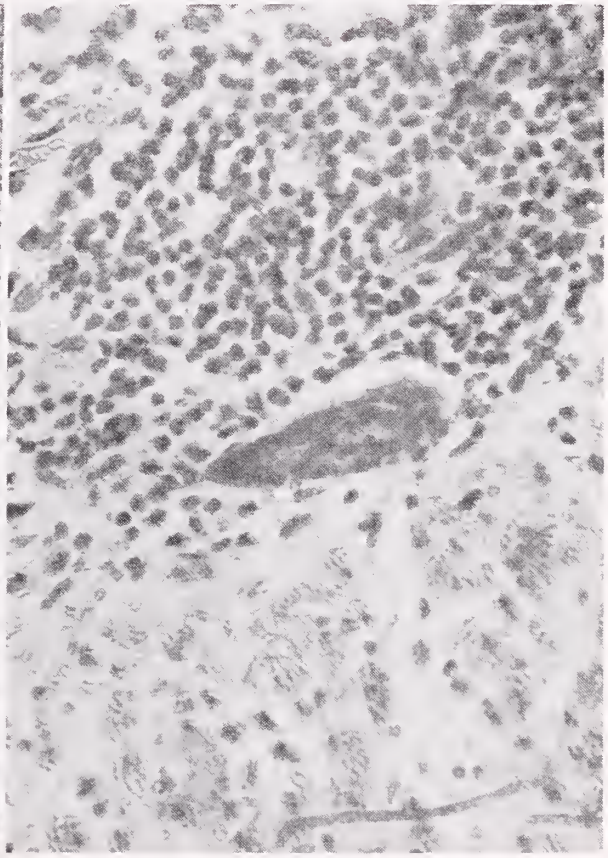


Figure 2.

remaining undiagnosed until clinical symptoms of invasion or metastasis develop. Early diagnosis of carcinoma of the appendix through clinical means has not yet been recorded; therefore, an attempt should be made to use current available diagnostic procedures. The early detection of deeply body-seated malignancy now requires utilization of new techniques in view of the fact that the clinical diagnosis is derived only from signs of complications or metastasis of the neoplasm, or both. These procedures should be used only when clinically these lesions are suspected in the absence of an acute appendiceal inflammation.

The most important early clinical signs are anterior or posterior, right or left quadrant discomfort with alternating symptoms of diarrhea with constipation. The complaint of abdominal discomfort, especially in the right lower quadrant, followed by rectal bleeding, weakness and anemia and a palpable mass may be the late metastatic and invasive symptoms. The following procedures may be of some help in the future for the early detection of primary adenocarcinoma of the appendix:

(1) Selective angiography has been used for early detection of neoplasm of brain and pancreas. Selective angiograms combined with hypotensive duodenography have revealed pancreatic neoplasms by their characteristic arteriographic and mucosal patterns. The regional vessels are abnormally displaced or encased or obstructed. Such angiography also may be attempted first for early diagnosis of carcinoma of the cecum whenever suspected (Figure 3).

(2) Sophisticated future procedures under research study are the following:

(a) Electronic radiography. This method uses an imaging chamber where the emitting electrons sharply delineate soft tissue and bone detail which may be selectively recorded for diagnostic study. Such studies are in process in various research centers. This may be supplemented by regional tomography whenever indicated. The currently used similar technique of radioisotopes with their diagnostic scans are very popular in clinical practice for detection of pathology wherever applicable (but not yet for the appendix).

Figure 3. (From NCME) Selective angiography of the superior mesenteric artery relieving a bleeding colonic diverticulum from the right colic artery. The middle colic and ileo-colic arteries are well illustrated.

(b) Echography has been used in quantitative evaluations of pericardial effusion, intercardiac masses and valvular heart disease, and of coronary artery disease. Echograms of various organs with their normal and abnormal contours may become typical of disease entities, inflammatory or neoplastic, and may eventually assist in early detection of malignancies in the G.I. tract also.

(3) The above-mentioned new procedures may be indicated in the near future but currently the fibro-optic colonoscope (Figure 4) may be utilized to identify and biopsy right colonic lesions. Wolfe and Shinya,[20] in 1973, removed 303 colonic polyps of which approximately eight per cent were located in the right colon, and in two cases of which a polyp was removed from the cecum. This procedure requires skill during instrumentation, and experience in the technique of biopsy and in the gross interpretation of the findings, but the mortality and morbidity are negligible as stated following 1600 fibro-optic colonoscopies. It may be helpful to utilize the fibro-optic colonoscope for diagnostic biopsies (Figure 5) of the lesions of the base of the appendix or for brush cytological biopsies of the mucosal lesions of the apex of the appendix during the early phase of the malignancy. This procedure combined with radiologic (contrast and air contrast enemas) and selective angiographic studies may be helpful in the early diagnosis of carcinoma of the cecum and of the vermiform appendix. With the hope that the foregoing recommendations may help the medical profession to document in the world literature the first case of carcinoma of the appendix diagnosed preoperatively, we declare that no effort should be spared in attempting to diagnose malignancy in its earliest stage.

Case Report

A 48-year-old white male was hospitalized on March 12, 1959, because of diarrhea, vomiting, anorexia and weight loss. He had a history of pulmonary tuberculosis diagnosed in 1958, at which time (May 1958) he was hospitalized at another hospital and treated with INH and PAS. He left that hospital against medical advice in

November 1958; he continued, however, on his prescribed medication at home. The patient consumed alcoholic beverages heavily. In 1949 he was hospitalized for Buerger's disease, at which time he had a left lumbar sympathectomy and amputation of the left big toe. He contracted syphilis at the age of 20, but a spinal tap in 1943 was negative.

Physical Examination.—The patient on admission complained of chest pain, dyspnea and diarrhea, weakness, weight loss and nervousness. Physical examination was negative except for the following: He had an abdominal scar in the left upper quadrant at the site of left lumbar sympathectomy. The left big toe had been amputated. The toes of both feet were cyanotic and cold, with no arterial pulsation. Clinically he appeared to be afebrile.

Laboratory.—WBC was 10,700 with 55 per cent polys, RBC showed 3,606,000, hematocrit 41 volume per cent, hemoglobin 12.2 per cent. Blood chemistry revealed BUN of 11.7 and FBS 77 mg. per cent. Sputum was positive for AFB and chest film revealed limited right upper lobe infiltration. Stools were negative for ova and parasites. Electrolytes were normal. Gastric analysis revealed a high total and free acidity. Serology was negative.

Hospital Course.—The patient was placed on antituberculous chemotherapy consisting of high doses of INH of 0.9 Gm. daily, Streptomycin 1 Gm. daily, and supplemental Pyridoxine of 50 mg. b.i.d. He was given Equanil 400 mg. q.i.d. Cardiovascular evaluation confirmed the diagnosis of arteriosclerosis obliterans and arteriosclerotic heart disease with a healed posterior myocardial infarction. No smoking was advised. An upper G.I. Series and small bowel series were normal. The patient complained of neuralgia; Streptomycin, therefore, was discontinued and was substituted with PAS in liquid form 4 Gm. four times a day.

Chest films (follow-up) and sputum remained unchanged but patient gained some weight. On June 23, 1959, the patient complained of crampy abdominal pain with tenderness in the right lower quadrant. There was no rebound tenderness or muscle spasm or guarding. Rectal examination was negative. Temperature was 99 F. WBC was 20,450 with 75 per cent polys. A sigmoidal growth was suspected by the surgical consultant and sigmoidoscopy followed by barium enema was performed and these procedures were reported negative.

On June 26, 1959, an exploratory laparotomy was performed which revealed an acute suppurative appendicitis with abscess formation and adherent loops of small bowel to the appendix. The appendix was removed in retrograde fashion with a small portion of the cecum. The patient did well postoperatively.

The pathological report of the resected specimen (Figure 1) revealed extensive inflammatory changes which were probably secondary to obstructive adenocarcinoma of the proximal portion of the appendix. Histologically, separation and perforation were confirmed. Microscopically, distally the wall was thickened and all coats were infiltrated with polymorphonuclear leukocytes and eosinophils (there was also a beginning of organization of fibropurulent exudate coming from the surface) but proximally an adenocarcinoma infiltrated the coats from beneath the surface of the epithelium to the subserosa. The tumor cells contained considerable mucus. Isolated glands were associated with exudate of poly-

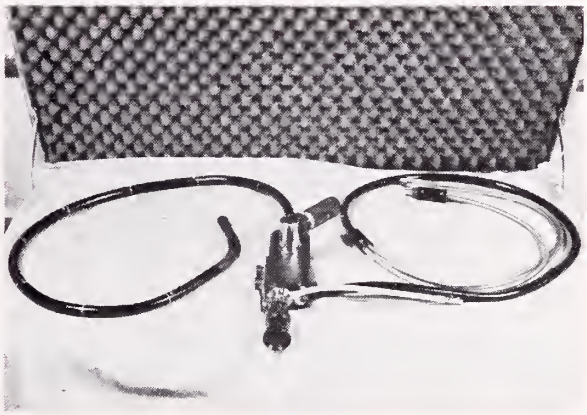


Figure 4

Figure 5. (From NCME) Visualization and biopsy of polyp of the ileo-cecal valve through colonoscope.

morphonuclear leukocytes and eosinophils. In the walls of the serosa there was an increase in number of plasma cells and leukocytes with accumulations of follicular type. Groups of tumor acini lay in the lymphatics. The pathological diagnosis was adenocarcinoma of the appendix with associated appendicitis, suppurative, with perforation.

The patient's postoperative course was uneventful. Electrolytes remained essentially normal. The patient continued on Streptomycin one Gm. daily, INH three Gm. three times a day and PAS, liquid form, four Gm. three times a day, which regimen was resumed on the 11th postoperative day. Blood volume revealed a 400 Gm. hemoglobin mass deficit for which he was given two pints of blood.

It was concluded that this patient should have a right hemicolectomy. Therefore, he was prepared with Neomycin and Sulfasuxidine and was digitalized preoperatively. On July 20, 1959, the patient underwent a right hemicolectomy with an end-to-side anastomosis. The resected specimen (Figure 2) revealed in the appendiceal amputation site (in only one section) a small, localized area of infiltration of tumor (similar to that described in the appendix). The tumor cells were found in groups with mucinous cytoplasm and hyperchromatic nuclei and were noted in the muscle coats and in the lymphatics. In addition, a foreign body granuloma was noted about the sutures in the cecal wall. The lymph nodes were negative for metastasis. The pathological report of the resected specimen was indicative of infiltrated adenocarcinoma of the cecum with activity at the resected site of the appendix, also foreign body granulomatous infiltration of the wall of the cecum and chronic active mesenteric lymphadenitis were noted.

On June 2, 1960, he was transferred to the Peripheral Vascular Service of another hospital because of progressive gangrene of the right fourth toe. During the time of his work-up at that hospital he left AWOL on July 10, 1960. Further follow-up of this patient was lost. It was learned later that he had deceased.

Discussion

Early detection of malignant lesions in general continues to tax the patient and the medical profession with the growing segment of the aging population. The initial silent or asymptomatic phase remains the desirable stage for curative elective operative procedure. During this stage, the lesion usually is localized without extension or metastasis. Detection of early G.I. lesions depends primarily on the patient's symptomatology. Proctosigmoidoscopies have been recommended for patients over 50 years of age. Secondary infections due to inadequate drainage have assisted the clinicians in early detection of obstructing neoplastic lesions of various organs such as the lung, gallbladder, renal pelvis, urinary bladder and, in our case, the appendix. The adenocarcinoma of the appendix as mentioned previously is located in 50 per cent of cases in the proximal third of the appendix, setting up an early suppurative appendiceal inflammation which alerts the physician to the fact of an acute abdomen, but the silent tumors of the distal portion of the appendix infiltrate the appendiceal wall by extension and may set up a vague discomfort in the right lower quadrant and, if this lesion extends into the cecum, may cause anemia. If the tumor involves the apex of a retrocecal appendix, the pathology may extend into the retroperitoneal space and set up some lumbar discomfort which may be attributed to a sacroiliac condition or to an arthritic spinal condition, or to right renal pathology, or even to a pancreatic or gallbladder condition. It is apparent that the diagnosis by clinical means will be delayed especially when the distal portion of the appendix is involved.

Since 25 per cent of the vermiform appendices are located retrocecally, it is of paramount importance to improve our diagnostic potential in this area. The retroperitoneal space with its intimate anatomic organic associations remains elusive in the hands of the most competent clinicians and diagnosticians. Retroperitoneal tumors (particularly lymphomas), idiopathic retroperitoneal and peri-ureteric fibrosis and pancreatic tumors may be suspected at the late pathological stage of the disease because of the nonspecific clinical symptomatology of these lesions consisting of malaise, perspiration, weight loss and back discomfort or pain. Other coincidental pathological findings may mislead the attending physician and cause him to overlook the main pathology in this space Conventional diagnostic procedures such as retroperitoneal pneumonography, intravenous pyelography and cholangiography, needle biopsy and tomography have been successful adjuncts in the diagnosis of these neoplasms. Clinical clues such as icterus, rapid weight loss, hepatomegaly, bowel irregularity, recurrent thrombophlebitis, psychiatric disorders, abnormal glucose tolerance tests and persistent back or abdominal pain (aggravated in the supine position) may make the clinician suspicious of a lesion in the retroperitoneal space. The majority of the retroperitoneal (or retrocecal) and intraperitoneal appendices can be diagnosed as disease entities when-

ever clinically an acute obstructive inflammatory or neoplastic process develops. The early diagnosis of adenocarcinoma of the appendix when clinically suspected or when diagnostically processed by exclusion requires the utilization of those sophisticated diagnostic techniques available presently and anticipated in the near future. The recently developed and proposed procedures of selective arteriography, electronic radiography and echography, if employed here, may improve the early diagnosis of these lesions, resulting in an improved five-year survival rate for these patients.

Lesions (especially carcinoma) of the right colon, despite the fact that the disease often remains completely limited to the bowel and to the adjacent mesentery for relatively long periods, have the same five-year survival rate along with the rapidly metastasizing lesions of the left colon because of the comparative delay in diagnosis of the lesions of the right colon. Abdominal pain or discomfort, malaise, anemia and bowel irregularity may mislead the physician into treatment of a coincidental or similar symptom-related disease until complications incidental or metastatic develop which will force the clinician to request an exploratory laparotomy. It is apparent, therefore, that new diagnostic techniques should be used, such as selective angiography, primarily in order to detect early malignancy of the cecum and possibly of the appendix. The visualization of the mucosal pattern of the cecum and of the ostium of the appendix has been attempted by recently introduced fibro-optic colonoscopes. This method, which is simple for the patient, could be used for early detection of carcinoma at these sites by direct biopsy or by aspiration for cytological studies in place of exploratory laparotomy which usually is performed at a later stage of the disease with metastases. Selective angiography may be used in debatable cases and in the future electron radiography and echography may be encouraged for detection of deeply seated malignancies of the G.I. tract or their adjacent secretory organs and glands. Currently it is apparent that the clinical diagnosis will be delayed and finally will be confirmed mostly by exploratory laparotomy following clinical exclusion. There has never been reported a case in which the clinical diagnosis of adenocarcinoma of the appendix was detected preoperatively. Review of the world literature also indicates that there has never been reported a case of primary carcinoma of the vermiform appendix in a patient with active pulmonary tuberculosis, as reported in this case.

Summary

1. A review of the literature is presented, with comment.

2. The use of new diagnostic techniques is proposed.

3. The treatment of choice for adenocarcinoma of the base of the appendix remains right radical hemicolectomy.

4. An additional case of adenocarcinoma of the appendix is reported.

5. This may be the first reported case in the world literature of adenocarcinoma of the appendix coincidental with active pulmonary tuberculosis.

A list of references may be obtained by writing The Journal.

184 Million Have Health Insurance

AN estimated 184 million people—about 9 out of every 10 people in the nation—had some form of private health insurance protection to help meet their medical bills as 1974 began. These figures were released recently by the Health Insurance Institute as part of its annual estimate of health insurance coverage in the United States.

The statistics show a continuing climb in private health insurance protection over the past 33 years. In 1940, when data were first recorded, 12 million Americans were listed as having some form of health insurance. Five years later 32 million had protection; by 1960 there were 130 million people with it; at the start of 1973, 181.6 million.

Hospital expense insurance, for example, had reached 184 million people at the start of the new year. Surgical expense insurance, which helps handle costs of operations, protected 168 million people as 1974 began.

Medical Grand Rounds

From the West Virginia University Medical Center

Edited By

Raymond B. Weiss, M. D.
Assistant Professor of Medicine

Gastrointestinal Hormones

Stuart T. Chen, M. D., Associate Professor of Medicine, Division of Gastroenterology, West Virginia University Medical Center.

ALTHOUGH it is not thought as such, the gut is an endocrine organ. Hormones produced in the gastrointestinal (GI) tract have multiple effects and the interactions of these hormones match in complexity those of the pituitary, thyroid and adrenal glands. The concept of hormonal control of physiologic function was first proposed and demonstrated in a laboratory of GI physiology, and secretin was the first substance to be called a hormone.

APUD Microendocrine System

Within recent years, the concept of a widely distributed microendocrine system has evolved. One of its most characteristic features is the ability to concentrate and decarboxylate biogenic amines. The system is therefore called APUD system (Amine Precursors Uptake and Decarboxylation). One simple method of tracing the embryological development of APUD system is to expose the embryo to hot formalin vapor which induces fluorescence of the APUD cells. Application of this technique to mouse embryos shows that the neural crest migrates in large masses in a ventral direction in the first eight days of embryonic life. On the ninth day they colonize the developing foregut and its derivatives such as the pharynx, stomach, duodenum, ultimobranchial body, and pancreas indicating APUD cells invade the gut. However, complete proof that APUD cells are the precursors of all endocrine polypeptide cells is not available. APUD cell types are listed in Figure 1. Tumors deriving from these cells and hormones secreted by those tumors are also listed.

Gastrin

In 1905, Edkins read before the Royal Society of London a brief paper "On the Chemical Mechanism of Gastric Secretion." The aqueous extracts from the gastric antral mucosa stimulated gastric secretion of HCl and pepsin. He named this physiologically active principle "gastrin," a contraction derived from the concept of a gastric secretin. Subsequent demonstration of histamine clouded Edkins' important observation.

Kamarov, in 1938, using extracts of gastric antral mucosa that had been prepared histamine-free, found a substance which stimulated the secretion of gastric acid. After five years and 50,000 hogs, Gregory and Tracy in 1964 succeeded in the isolation of two nearly identical peptide hormones. They designated these hormones Porcine Gastrin I and II, and defined the sequence of their 17 amino acids. One of the most fascinating observations is that the tetrapeptide amide (Tryp-met-asp-phe-NH_2) of the carboxyl terminus contains all the physiological properties of intact gastrin. On a molar basis, however, gastrin tetrapeptide amide is substantially less potent than the intact gastrin molecule. The following summarize the physiology of gastrin release and inhibition.

Stimuli of gastrin release:

1. Chemical stimuli: meat extracts, amino acids, ethanol, local acetylcholine, hypercalcemia.
2. Mechanical stimuli: distention of the gastric antrum by food.
3. Vagal stimulation: produced by insulin—induced hypoglycemia.
4. Catecholamines.

Inhibition of gastrin release:

1. Acid in the antrum: the degree of the inhibition of gastric release is proportional to the acidity. pH 1.0 inhibits release completely, and a solution of intermediate acidity (pH 3.5) inhibits partially.
2. Topical painting of the pyloric gland area with 2 per cent cocaine inhibits gastrin release.
3. Atropine: more effective in suppressing acid secretion than in blocking gastrin release.

Circulating gastrin is heterogenous. The principal molecular species is not heptadecapeptide gastrin, but rather a larger molecular species

which is termed "big gastrin" (BG). At least one more kind is identified, and called "big, big gastrin" (BBG). Big gastrin and BBG reside principally in the duodenum and jejunum, whereas heptadecapeptide gastrin mainly in the antrum. BG and BBG yield on trypsin hydrolysis a polypeptide which is indistinguishable from heptadecapeptide gastrin. In addition to heptadecapeptide and big gastrin, little gastrin and minigastrin have been identified in Zollinger-Ellison syndrome. Utilizing an immunohistochemical technique gastrin has been demonstrated in the mucosa of the small intestine as well as in the pancreas. The quantity of gastrin in the small intestine progressively diminishes caudally. The mucosa of the first portion of the duodenum contains as much or nearly as much gastrin as the antral mucosa.

G-cells (gastrin cells) are located principally in the antral pyloric glands. Many of these cells have free surfaces which are exposed to the gastric lumen and to the lumen of individual pyloric glands. The normal human pancreas contains gastrin which is located in the cytoplasm of delta cells. An increased number of gastrin cells in the gastric mucosa has been demonstrated in the following: pernicious anemia, hypersecreting patients without Zollinger-Ellison syndrome (ZES), acromegaly, hyperparathyroidism, and occasionally in duodenal ulcer patients.

Radioimmunoassay of gastrin was accomplished in 1968. With this tool to measure serum concentrations of gastrin, a number of studies have been done to correlate gastrin levels with clinical problems. A very high serum gastrin concentration has been demonstrated in ZES and pernicious anemia. Duodenal ulcer (DU) patients showed no significant difference in serum gastrin from controls. However, the post-feeding plasma gastrin level is higher in DU patients than in controls. This may be related to increased post-prandial acid output in these patients. Increased acidity in the duodenum plays an important role in causation of a duodenal ulcer.

Mean fasting serum gastrin concentration in severe renal failure is significantly elevated since the kidney is important in metabolic degradation of gastrin. One could postulate that there might be a higher incidence of peptic ulcer in patients with chronic renal failure, but I have not observed this to be true.

Following a test meal (4 oz. orange juice, 2 eggs, one piece of dry toast), normal subjects respond with an average of three-to four-fold rise in plasma gastrin, whereas ZES patients show no rise. Atropine fails to prevent a post-feeding rise in plasma gastrin concentration in the humans. On the contrary, atropine may cause greater rise in post-prandial plasma gastrin via delayed gastric emptying. An important clinical application of this knowledge is that anticholinergic drugs may even be harmful for duodenal ulcers.

Calcium infusion induces elevation of both serum gastrin and gastric secretion in normal subjects. This is the probable explanation for why patients with hypercalcemia are prone to peptic ulcers. An even greater response to calcium infusion is observed in DU patients, and an even much greater response in ZES. In one reported patient with ZES and hyperparathyroidism, marked decline in plasma gastrin concentration occurred following parathyroidectomy.

In a study of subjects with Billroth II anastomosis the basal and post-prandial gastrin levels were significantly lower than patients with a Billroth I or vagotomy-pyloroplasty. This study indicated that food entering the duodenum is capable of stimulating gastrin release after the gastric antrum is resected.

Case Presentation of Zollinger-Ellison Syndrome

A 41-year-old man was admitted for the first time to the West Virginia University Hospital in January 1973 for recurrent peptic ulcer.

He was well until 1966 when he developed epigastric distress, nausea and vomiting. He was x-rayed and told that he had "ulcers." In the same year he had hematemesis and melena for which he was treated medically. Epigastric pain persisted. In 1967 he had recurrent upper GI bleeding, and vagotomy and pyloroplasty were performed. Ulcer symptoms recurred over the next year despite good medical management. He underwent a second operation in February 1969, and a partial gastrectomy was attempted but was abandoned because of massive bleeding. Transthoracic vagotomy was performed in the same month. In November 1971 he underwent antrectomy and Billroth II reconstruction for a recurrent ulcer. This was complicated by evisceration and outlet obstruction. Marginal ulcers were demonstrated by x-ray in October 1972 and January 1973.

Physical examination revealed a well-nourished and well-developed man in no acute distress. Vital signs were normal. The examination was otherwise unremarkable.

The following laboratory tests were all within normal limits: blood counts, serum calcium and phosphorus, serum electrolytes, glucose tolerance test, T4, 24-hour urinary 17-ketosteroids, and

plasma cortisol. Skull x-ray was negative. An UGI showed a postoperative Billroth II anastomosis. There were two ulcers on the jejunal side. Twelve-hour overnight gastric secretion was 1,475 ml. with free acid of 56 mEq/L and total acid of 72 mEq/L. The pH was 1.16. Serum gastrin level was 1,444 pg/ml by radioimmunoassay (normal range is up to 300 pg/ml).

At surgery there was a small 1 cm. nodule on the duodenal wall a few cm. from the duodenal stump. The tumor was removed. A repeat serum gastrin 10 days following surgery was under 100 pg/ml.

At pathology a yellowish firm nodule was noted within the submucosa of the duodenal wall. Microscopically, it was a carcinoid islet-cell tumor of the duodenum.

Zollinger-Ellison Syndrome (ZES)

In 1955, Zollinger and Ellison reported two patients with a triad of: (1) fulminant peptic ulcer disease that recurred despite repeated gastric operations, (2) gastric hypersecretion, and (3) a non-beta islet cell tumor of the pancreas. Zollinger and Ellison were the first to postulate that a hormone from the tumor was responsible for the disease. They suggested that glucagon might be the hormone. It is now known that gastrin is hypersecreted by the tumor.

Extensive discussion on ZES is beyond the scope of this presentation and I shall mention only some pertinent facts. Basal plasma gastrin levels are below 300 pg/ml in a normal population. In ZES, the basal level is elevated between 3 and 3,000 times that of normal.

Pathologically, 60 per cent of ZES is due to a malignant tumor; 20 per cent, single adenoma; and the remaining 20 per cent, hyperplasia or multiple adenomas of pancreatic islet cells. In addition, approximately 20 per cent of ZE patients have clinical or pathological evidence of multiple endocrine adenomas involving other glands such as the pituitary and parathyroid glands.

Occasionally, a single islet cell tumor may produce more than one islet cell hormone. Some examples of multiple hormone secretion by islet cell tumors include: gastrin, ACTH, and MSH; insulin and gastrin; insulin, gastrin and glucagon; gastrin and serotonin; gastrin, serotonin and histamine.

Most of the gastrin-secreting tumors originate from the pancreatic islet cells. Occasionally, one can arise as a carcinoid tumor in the duodenal wall. Hyperplasia of gastrin cells of the gastric antrum has been reported to be the cause of ZES in one case. He was a 17-year-old male with a four-year history of duodenal ulcer. Fasting plasma gastrin was over 8,000 pg/ml. At laparotomy, no pancreatic or other tumors were found. Truncal vagotomy, antrectomy, and distal pancreatectomy were performed. Immunofluorescent staining of the surgical specimen showed hyperplasia of gastrin cells in the resected antrum. The pancreas and duodenum were normal. Fasting plasma gastrin was less than 50 pg/ml two months after surgery, and the gastric acid was reduced by 92 per cent.

It has been recently reported that serum gastrin is elevated in patients with rheumatoid arthritis. It is well known that rheumatoid arthritis patients (particularly those on aspirin therapy) are prone to developing peptic ulcer disease. Excessive serum gastrin may contribute to formation of peptic ulcer in these patients.

Secretin

In 1902, Baylis and Starling observed the increased flow of pancreatic juice after acid was put into the lumen of the denervated jejunum. The substance which stimulated the secretion was termed secretin. Mutt and Jorpes in 1966 described the molecular structure of the hormone. Bodanszky and co-workers synthesized it in the same year. Secretin is a strongly basic single-chain polypeptide with 27 amino acids. There is a notable similarity between the molecular structure of secretin and glucagon; i.e., 14 of the 27 amino acids occupy the same position.

Stimuli for the release of secretin are as follows: (1) HCl (pH less than 4.5) is the most potent stimulus; (2) Hydrolysis products of protein and fat may be stimulatory; and (3) A local neural mechanism may play some part, since topical anesthetics reduce pancreatic secretion response.

Secretin induces the secretion of water and bicarbonate by the pancreas. Secretin has little effect on enzyme secretion since the acinar cells in the pancreas do not discharge their granules after the administration of secretin. Secretin stimulates the liver to secrete bile with a high concentration of bicarbonate but it is probably not an important physiologic stimulus of hepatic secretion. Gastric acid secretion, stimulated by gastrin, is inhibited by secretin. Gastric motility and esophageal sphincter pressure are reduced by secretin.

Our knowledge of secretin has practical application in diagnosis. One application is the Secretin Test. The Secretin Test is used chiefly to diagnose inflammatory and neoplastic disease of the pancreas. Normal individuals secrete

at least 2 ml. of pancreatic fluid per kilogram of body weight in 80 minutes following secretin infusion (1 unit/kg body weight). Duodenal bicarbonate concentration increases to at least 85 mEq/L and amylase secretin up to 6 units/kg in the 80-minute collection. Patients with chronic pancreatitis early in the disease fail to produce a normal rise in bicarbonate concentration. Late in the disease the volume flow may also fall off. Patients with cancer of the head of the pancreas tend to exhibit normal ductal secretion of bicarbonate in response to secretin but show reduced flow.

Another application is in angiography. When large doses of secretin are injected into the superior mesenteric and celiac arteries before the injection of contrast medium the time needed for arterial filling is shortened, the vessel diameter is increased, and the diagnosis of carcinoma and cysts of the pancreas is facilitated.

It has been speculated that secretin might even be effective therapeutically in treating duodenal ulcer by stimulating secretion of alkaline pancreatic juice and suppression of gastric acid output. Further investigation, however, is needed before it can reach clinical use.

Cholecystokinin-Pancreazymin (CCK-PZ)

CCK and PZ have been shown to be an identical polypeptide hormone. CCK is a polypeptide hormone containing 33 amino acids. The hormone has been prepared in pure form from duodenal mucosa. The distribution of CCK in the gastrointestinal tract is similar to that of secretin.

Digested products of foods such as polypeptides, amino acids and emulsified fats are believed to be the most potent stimuli to the release of CCK. Acidification seems to be almost ineffective in man. Pure solutions of simple sugars show little effect. The vagus nerve exerts a tonic influence on pancreatic enzyme secretion but atropine does not block the responses of the pancreas to parenterally injected CCK.

CCK acts primarily to increase the enzyme output from the pancreas, to cause a powerful contraction of the gallbladder, and to stimulate the bile flow. CCK also increases intestinal motility and decreases intestinal transit time.

WDHA Syndrome (Watery Diarrhea, Hypokalemia, Achlorhydria Syndrome)

Verner and Morrison (1958) drew attention to a syndrome of fulminating diarrhea, severe hypokalemia, and death from renal failure in association with non-beta islet cell tumor. More than 50 cases have been reported since then. The most life-threatening problems are watery diarrhea, severe hypokalemia, and severe metabolic acidosis. This group of patients represent approximately 5 per cent of all those with hormone-producing non-beta islet cell tumors of the pancreas. Achlorhydria was documented in 1961, which could be a distinguishing factor in this group from ZES. Hypochlorhydria rather than achlorhydria is a more common finding in WDHA syndrome.

Elevated blood sugar is found frequently in this syndrome. Normoglycemia has frequently followed complete excision of the pancreatic tumor and control of diarrhea. The most plausible explanation for hyperglycemia is the potassium imbalance. Elaboration of glucagon by these tumors remains an unproven possibility.

Hypercalcemia is seen in approximately 60 per cent of the patients with this syndrome. The frequency of hypercalcemia is more than twice that of patients with ZES. Of 27 patients with WDHA syndrome whose serum calcium was measured, 25 had elevated values ranging from 11.4 to 16.2 mg%. Initial parathyroid surgery failed to control hypercalcemia, but successful removal of the pancreatic neoplasm normalized the serum calcium. The cause of hypercalcemia probably is the elaboration of a parathormone-like substance by the pancreatic islet tumors.

The neoplasms are usually discrete, and approximately 80 per cent are within the body and tail of the pancreas. To date, there have been no primary extrapancreatic sites. Extirpation of the pancreatic lesion is the only definitive therapy. When extirpation is not feasible, ACTH and corticosteroids have been beneficial in treating the fulminating diarrhea.

Etiology of this syndrome is unclear. Secretin, gastrin, glucagon, and gastric inhibitory polypeptide (GIP) have been incriminated. Secretin and secretin-like hormones have been identified by bio- and immunoassays in the tumor extract and by bioassay of plasma from the patients with WDHA syndrome. Secretin and secretin-like substance from the tumor extract has been shown to reduce net absorption across a gut membrane, to increase secretion from human small bowel, to induce hypercalcemia in normal and ZES subjects, and to inhibit gastrin-stimulated acid production. Gastrin and glucagon were shown to reduce net absorption across intestinal mucosa. Gastrin inhibitory polypeptide (GIP) is a potent inhibitor of gastric secretion and it has stimulatory effects on intestinal secretion. Immunofluorescence reaction of the tumor cells was strongly positive for GIP. It may be that all these substances work at the cellular level resulting in the cholera-like diarrhea.

Gastric Inhibitory Polypeptide (GIP)

Enterogastrone was originally used to describe the humoral substance which is released from the small intestine after the arrival of fat, and then inhibits gastric secretion. CCK and secretin inhibit gastrin-stimulated but not histamine-stimulated gastric acid secretion. Pederson and Brown have recently reported a purified polypeptide that inhibits acid secretion that is stimulated by histamine, pentagastrin or insulin-induced hypoglycemia. This substance has been termed gastric inhibitory polypeptide (GIP). Theoretically, GIP would have clinical value in the treatment of ulcer disease. A major dis-

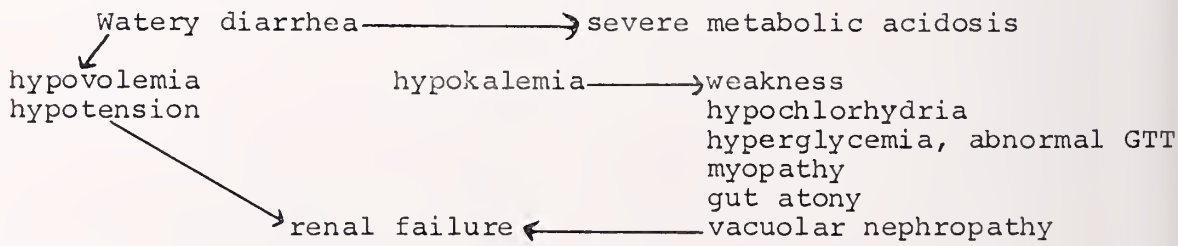
APUD (Amine Precursor Uptake and Decarboxylation) System Tumors and Their Hormones

Tissue	Tumor	Hormones
1. Pancreatic islet cells	Islet cell adenoma	Insulin Gastrin Secretin-like hormone ACTH, melanocyte-stimulating hormone Serotonin Gonadotropin Glucagon GIP (gastric inhibitory polypeptide) ADH (antidiuretic hormone) Aldosterone Catecholamine Parathormone
2. Pituitary corticotrophs and melanotrophs (basophils)	Pituitary adenoma	ACTH, MSH
3. Thyroid parafollicular cells	Medullary carcinoma	Prostaglandins Serotonin Calcitonin
4. Gastrointestinal argyrophil and argentaffin cells	Carcinoid	Gastrin Serotonin
5. Adrenal medullary cells	Pheochromocytoma	Catecholamines

Figure 1

1. Synonyms: Verner-Morrison syndrome, pancreatic cholera, diarrheogenic syndrome

2. Pathophysiology



3. Tumor: Pancreatic islet cell tumor

4. Etiology: Excess production of (1 or more):
   a. Secretin-like hormone
   b. Combination of gastrin and glucagon
   c. Gastrin inhibitory polypeptide (GIP)

5. Other findings: Hypercalcemia

Figure 2. WDHA Syndrome.

advantage, however, is that being a polypeptide hormone, it has to be administered parenterally.

Enteroglucagon

In the past, glucagon was thought to be a hormone found in the pancreas. However, glucagon-like immunoreactivity has been found in the GI tract and is called enteroglucagon. Cells containing glucagon-like immunoreactivity have been found in the fundus of the stomach and in jejunum.

Enteroglucagon rises in serum during intestinal absorption of glucose and thus stimulates release of insulin from the pancreas. Enteroglucagon, however, differs from pancreatic glucagon. Glucose given by mouth is cleared more rapidly from the blood and elicits a greater insulin response than glucose given intravenously. Secretin, CCK, and enteroglucagon have been shown to promote insulin release. In post-gastrectomy hypoglycemia or dumping syndrome, there may be excessive stimulation of insulin secretion because some intestinal hormones are released by the rapid introduction of carbohydrates into the small intestine, thus resulting in the typical symptoms of that syndrome.

Other Gastrointestinal Hormones

Other hormones have been identified, but their physiological significance is unclear. Motilin is a polypeptide which increases motor activity in the stomach. It is released after alkalinization of the duodenum. Villikinin is an intestinal hormone affecting contraction and relaxation of the villi of the small intestine.

Summary

There is a remarkable interrelationship of the GI hormones. Grossman postulates that gastrin, secretin, and CCK all act on one receptor. This receptor has two interacting sites, one with affinity for gastrin and CCK, and the other with affinity for secretin and glucagon. Simultaneous actions of gastrin and cholecystokinin lead to competitive augmentation or competitive inhibition. Simultaneous action of secretin with either gastrin or CCK leads to non-competitive inhibition or non-competitive augmentation.

The categories of actions of the hormones include (1) water and electrolyte secretion by the stomach, pancreas, liver and Brunner's glands; (2) water and electrolyte absorption from ileum and gallbladder; (3) enzyme secretion by the stomach and pancreas; (4) endocrine secretion of secretin, gastrin, insulin, and glucagon; (5) contraction and motility of the esophagus, stomach, intestine, biliary tract, and uterus; and (6) a trophic effect on gastric mucosa, pancreas, small bowel, and liver. Because of such a diversity of action, delicate balance, and complicated interrelationship of these GI hormones, it is conceivable that many clinical disorders may result from pathological over-production of a hormone or hormones (ZES, WDHA syndrome) or from breakdown of hormonal interrelationships (dumping syndrome, peptic ulcer disease, rapid intestinal transit). Understanding of the basic physiologic mechanisms of these hormones allows understanding of the pathologic clinical problems.

A list of references may be obtained by writing The Journal.

Problems of Aging Auto Drivers

THE problems of the aging autoist whose driving may have to be restricted or discontinued will be the theme of a National Conference on the Aging Driver May 2-4 in Washington, D. C. The conference will be sponsored by the American Medical Association and the American Association of Motor Vehicle Administrators.

While the Conference will focus on the medical aspects of licensure problems of the aging driver, related factors such as public transportation, housing, community design, insurance and finances will be covered. Participants will include physicians and licensing officials, as well as representatives of voluntary organizations, insurance companies, governmental agencies, private safety organizations and other interested groups.

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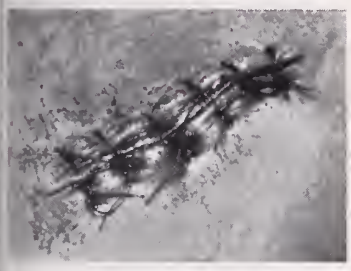

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Warnings: *Idiosyncratic Reactions:* Rarely, first dose has been followed by extreme weakness, transient quadriplegia, dizziness, ataxia, temporary vision loss, diplopia, mydriasis, dysarthria, agitation, euphoria, confusion, disorientation. Symptoms usually subside during the next several hours. Supportive and symptomatic therapy, including hospitalization, may be necessary.

Pregnancy and Lactation: Safe use not established; weigh potential benefits against potential hazards in pregnancy, nurs mothers, or women of childbearing potential.

Children Under Five: Drug not recommended.

Potentially Hazardous Tasks: Driving a motor vehicle or operating machinery.

Additive Effects: Possible additive effects between carisopro alcohol, and other CNS depressants or psychotropic drugs.

Drug Dependence: Use cautiously in addiction-prone patie

Precautions: To avoid excess accumulation, use caution in patients with compromised liver or kidney function.

Adverse Reactions: *Central Nervous System:* Drowsiness, dizziness, vertigo, ataxia, tremor, agitation, irritability, headache depressive reactions, syncope, insomnia.

Allergic or Idiosyncratic: Usually seen after 1-4 doses in patie not previously exposed, e.g., rash, erythema multiforme, pruritus, eosinophilia, fixed drug eruption with cross reaction t meprobamate. More severe manifestations: asthma, fever, weakness, dizziness, angioneurotic edema, smarting eyes, hypotension, anaphylactoid shock. Stop drug, treat symptomatically (e.g., possible use of epinephrine, antihistamin and in severe cases corticosteroids).

Cardiovascular: Tachycardia, postural hypotension, facial flushing.

Gastrointestinal: Nausea, vomiting, hiccup, epigastric distres

Hematologic: Leukopenia and pancytopenia (on carisoprodol plus other drugs).

Usual Adult Dosage: One 350 mg tablet three times daily and at bedtime.

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The President

ONE OF THESE DAYS

THE recent flap over pre-certification with the subsequent apparent change and perhaps withdrawal is an excellent reminder about the concept of gradualism. One can tolerate extremely high water temperature if one gradually heats the tub while sitting with the hot water faucet open. However, one would be repelled if going into such hot water directly. The Feds violated this time-honored concept of just a little bit at a time and thus the resultant flap.

This slowly progressive gradualism shows no sign of abating. The PSRO mechanism impresses me as being a "can't win hand" for the doctors. After two years of operation it is to be reevaluated. The discussion then will not mention the 999 instances of compliance but rather the one instance of non-compliance. Then will follow the familiar chant—the doctors can't regulate themselves. We are the most disciplined of the professions. No group approaches our continuing education efforts. The reward for endeavor appears to be harassment.

Anyhow, one of these days the doctors are going to say to hell with all these forms. Forms don't bleed, suffer, get short of breath, develop acute rentention or even irregularity. Perhaps the doctors may independently but simultaneously neglect these forms until somebody gets the message. One of these days.

The above remarks represent the personal opinion of Dr. Tom McCoy and in no way should be considered as the official policy of the Association.

Tom McCoy

A. THOMAS MCCOY, M. D., *President*

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Editor
GEORGE F. EVANS, M. D.
122 South Sixth St.
Clarksburg, W. Va.

Managing Editor and
Business Manager
MR. WILLIAM H. LIVELY
Box 1031
Charleston, W. Va. 25324

Associate Editors:
VERNON E. DUCKWALL, M. D.
Elkins
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EDITORIALS

ON THE PROSTITUTION OF THE PHYSICIAN

The annual routine physical examination was over. She was a well-developed, well-nourished, white female as so many physical examinations begin. I had reassured her that we had done a pap smear and that her laboratory findings were in order. As I was turning to leave the examining room she said, "Oh doctor, would you mind writing a letter for me saying that I ought to weigh 145 pounds?"

I replied that I thought that her ideal weight was somewhat less than that. She responded that she knew that because she went to Weight Watchers and was told that she should weigh 138 pounds, but that she did not want to weigh less than 145 pounds.

"That's simple enough," I replied, "When you reach 145 pounds just drop out of Weight Watchers."

"Oh, that's not possible," she said. "I work with Weight Watchers and I must weigh in every week. If I am less than two pounds over my weight goal I don't have to pay anything."

The more I thought about this conversation the more rebellious I felt. My opinion was not being sought, I was not being asked what bit of advice I might be able to impart from some 20 years of study. I was simply being used.

I thought about the number of times that I have spent an extra two minutes hastily scribbling on a prescription blank: "This is to certify that Mr. X brought his wife to the office for examination today." This was done at the patient's request so that her husband, who works for a company that demands this, may collect his Christmas bonus some nine to ten months hence.

I thought about the leering grin of the gaunt man who was suffering from alcoholic gastritis as he asked for a certificate saying that he was seen in the emergency room at 3:00 A.M. He had been drinking for more than 12 to 20 hours and was too inebriated to work. He also had a gastritis and was vomiting. He grinned a sickly triumphant grimace as he received the prescription blank saying he had been to the emergency room. "I work the Hoot Owl Shift," he said. "I need this to get my sick pay."

I thought about the form required by some counties in Virginia so that a pregnant high school girl may obtain a homebound teacher. That form requests that I certify that she is medically unable to attend school because of her pregnancy. Yet, it is perfectly all right for her older sister to attend college at the same state of pregnancy. If the county wishes to assign a homebound teacher to every pregnant high school girl, I have no objection except that it seems to be a waste of the taxpayers' money. Why do they feel bound, however, to involve a busy physician to certify that someone who is healthy enough to attend school cannot attend because she is sick?

The American physician is coerced into serving as a policeman, a truant officer and a "parent

who must write teacher a note" for people of all ages and in all walks of life.

If the average physician spends only two to three minutes per day engaged in this type of activity, it will amount to 10 to 15 minutes a week. This is roughly 12 hours a year not counting two weeks off for vacations or meetings. I'm sure that the physician regrets this loss of a day and a half of his time; and it represents a small loss to the community. The real loss, however, is in the physician-patient relationship. The patient is being forced by the demands of society to coerce his physician into a position for which he is not trained. Neither is the physician desirous of being placed in this position.

By what he writes the physician frequently may change the material benefits accruing to the patient. The patient is quite aware of this and may be tempted to urge a physician to overemphasize certain aspects of the medical situation in order to obtain benefits which would not otherwise be warranted. This situation is typified by the patient who is desirous of having elective sterilization because many insurance companies will not cover the cost of sterilization when it is requested by the patient and her husband because of age and parity. It would appear advantageous to the insuring companies to cover the cost of elective sterilization because it would prevent much more expensive complications with pregnancies that would occur if sterilization were not performed.

Furthermore, an occasional patient will report in a disgruntled manner that the agent of the insurance company who sold her her policy has informed her that if the doctor will simply write a letter saying she has high blood pressure or some other medical problem the company will pay the cost of her sterilization. Even when considerable time is taken explaining to the patient that the company may request a discharge summary or all portions of the chart to validate any such letters and that the doctor has no intention of falsifying material some of these patients still do not appear to understand why the simple formula of the insurance agent cannot be followed.

I have no panacea to offer for this prostitution of the physician; but would not it be delightful to be accepted for what we are: neither put upon a pedestal nor used as whipping boy; but accepted as members of the community who try to help other members of the community to better health. —*Guest Editorial by T. Keith Edwards, M. D., Member of the Staff, Department of Obstetrics and Gynecology, Bluefield Sanitarium, Bluefield, West Virginia.*

New TV Series Scheduled On 'Today's Health'

The American Medical Association and Standard Brands, Inc. jointly announced a new television series titled "Today's Health." The series is being produced by Gittelman Film Associates in association with the AMA consumer magazine of the same name. This syndicated weekly half-hour series is designed to explore varied aspects of health and medicine. Material from the AMA magazine will be utilized; AMA experts and editors will act as consultants.

"Today's Health" will be co-hosted by Norman Pastorek, M. D., who teaches at the New York Hospital-Cornell Medical Center and is in practice in New Rochelle, and Carlin Glynn, actress, mother of three, and an active participant in a consumer action group, "Consumer Action Now," has appeared on TV and talk shows in U. S. and Canada on behalf of CAN.

Each half-hour will be done in three segments. The first will provide information and up-to-the-minute developments in health and medicine. The second segment, filmed on location, will involve nationally known figures and their stories in the combatting of personal health problems. For example, in the first show Peter Sellers will discuss how he has coped with a coronary attack that almost killed him, and how he has pursued an active career following his illness.

The third segment can best be described as an informal dialogue involving health authorities on provocative subjects which would encompass material the viewers might rather not hear about themselves, but really want to know.

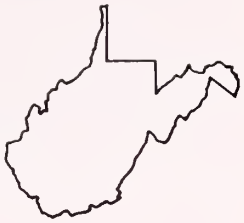
The "Today's Health" series is a part of a continuing effort by Standard Brands, Inc. to impart sound nutritional and medical information to the American people, and is primarily sponsored on behalf of Fleischmann's 100 per cent corn oil margarine, and Egg Beaters, the new cholesterol-free egg substitute.

Philip Gittelman, president and executive producer of GFA, was formerly the producer for CBS news involved in the development and production of the award-winning Hidden Revolution series hosted by the late Ed Murrow. Other series written and produced by Gittelman were New Portrait with Charles Collingwood, Close Up with Mike Wallace, as well as various public affairs documentaries.

"Today's Health" is being distributed through television stations on a trade basis beginning April 1974 by Ted Bates Advertising, Inc. According to Joel Segal, Senior Vice President, Network and Syndication Division of the Media Programs Department, "We have already had significant expressions of interest from stations for a series of this nature involving meaningful information presented in an entertaining fashion."

It is hoped that 60-100 TV stations will schedule "Today's Health" with an estimated audience of seven million.

GENERAL NEWS



AMA President Honor Guest At 107th Annual Meeting

Dr. Malcolm C. Todd of Long Beach, California, President Elect of the American Medical Association, will be among the honor guests at the 107th Annual Meeting of the West Virginia State Medical Association which will be held at The Greenbrier in White Sulphur Springs, August 21-24.

Malcolm C. Todd, M. D.

Dr. J. Hugh Wiley of Morgantown, Chairman of the Program Committee, said Doctor Todd has accepted an invitation to speak at the first session of the House of Delegates on Wednesday afternoon, August 21. Doctor Todd, a general surgeon, will be installed as President of the American Medical Association during the annual meeting at Chicago in June. He will succeed Dr. Russell B. Roth of Erie, Pennsylvania, the current President.

A native of Carlyle, Illinois, Doctor Todd received degrees from the University of Illinois and Northwestern University before receiving his M. D. degree in 1938 from Northwestern. He interned at St. Luke's Hospital in Chicago and served a three-year surgical residency at Cook County Hospital in Chicago. He was a member of the faculty at Northwestern until 1942 when he entered World War II, serving as chief of surgical services at several hospitals in the European Theater.

Following the war, Doctor Todd opened his solo general surgery practice in Long Beach and still continues to maintain his practice. He also serves as attending and consulting surgeon for several hospitals in the Los Angeles area.

A Diplomate of the American Board of Surgery, Doctor Todd also is a Fellow of the American College of Surgeons, the International College of Surgeons, the American College of Gastroenterology and the Royal Society of Medicine.

Doctor Todd is considered one of the nation's foremost authorities on health manpower needs and has served twice as Chairman of the AMA's Council on Health Manpower which has played a major role in the AMA's efforts to alleviate shortages of physicians and allied health professionals.

From 1959 until being named President Elect of the AMA, he was a member of the California delegation to the AMA House of Delegates. He had been a member of the California Medical Association's House of Delegates for a number of years and was a member of the CMA Council before serving as President of the Association in 1968-69.

Program Nearly Completed

Doctor Wiley announced that the program for the meeting has been completed with the exception of making final arrangements for breakfast meetings of the various sections and affiliated societies. Names of the other prominent physicians and surgeons who have accepted invitations to appear as guest speakers will be announced in future issues of *The Journal.*

Senator Byrd Keynote Speaker

The Program Committee announced previously that Sen. Robert C. Byrd of West Virginia would deliver the "Thomas L. Harris Address" at the opening of the first general scientific session on Thursday morning, August 22.

The scientific session that morning will be devoted to a "Symposium on Newer Concepts in Infectious Diseases."

It was announced previously that Dr. James F. Glenn of Durham, North Carolina, and Dr. Allen H. Mackenzie of Cleveland are scheduled to present papers at the second general scientific session on Friday morning, August 23.

Saturday Morning Session

Doctor Wiley said that a portion of the Saturday session at The Greenbrier will be devoted to a symposium on "What Are the Barriers to an Improved Medical Practice in the State of West Virginia?" Doctor Wiley has expressed hope that several department heads of state agencies will be able to attend to help provide answers to questions from the audience.

Doctor Wiley also has announced that all members of the Association are invited to send to him any complaints or suggestions as to how the practice of medicine can be improved in the State. He said this would aid the Committee considerably in arranging the agenda.

Serving with Doctor Wiley on the Program Committee are Drs. John T. Chambers of Charleston, William E. Gilmore of Parkersburg, Ray M. Kessel of Logan, Winfield C. John of Huntington and Philip M. Sprinkle of Morgantown.

Business Meetings Scheduled

The Pre-Convention Meeting of the Council will be held on Wednesday morning, August 22, and the first session of the House of Delegates that afternoon.

Dr. A. Thomas McCoy of Charleston, the President, will deliver his Presidential Address at the final session of the House of Delegates on Saturday afternoon, August 24.

Ohio State Medical Assn. Annual Meeting May 12-15, Cleveland

West Virginia physicians have been invited to attend the 1974 Annual Meeting of the Ohio State Medical Association, May 12-15, in Cleveland.

The Sheraton-Cleveland Hotel will be headquarters for all business sessions, scientific sessions and exhibits.

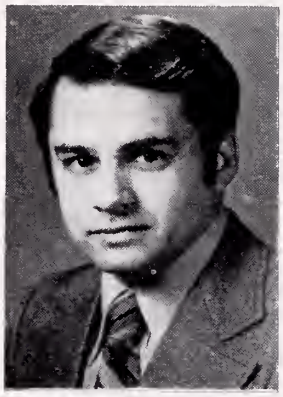
The OSMA House of Delegates will hold its first business session on Sunday, May 12, beginning at 7 P. M., and its final session on Wednesday, May 15, at 3:30 P. M.

A social function will be held Tuesday evening at the Frederick C. Crawford Auto-Aviation Museum.

For additional information contact the OSMA at 17 South High Street, Suite, 500, Columbus, Ohio 43215.

State Surgeon's Chapter To Meet May 1-4 At The Greenbrier

The West Virginia Chapter of the American College of Surgeons will meet May 1-4 at The Greenbrier in White Sulphur Springs.



Joseph C. Maroon, M. D.

Richard T. Myers, M. D.

One of the principal speakers will be Dr. Richard T. Myers of Winston-Salem, North Carolina. Doctor Myers, who is Professor and Chairman of the Department of Surgery at the Bowman Gray School of Medicine of Wake Forest College, will deliver two addresses. His topics will be "Diagnosis and Management of Hyperparathyroidism," and "Surgical Aspects of Unusual Biliary Tract Disease."

Officers of the West Virginia Chapter are Drs. James P. Thomas, Bluefield, President; A. S. Daniel, Wheeling, Vice President; Alvin L. Watne, Morgantown, Secretary-Treasurer, and William E. Gilmore, Parkersburg, Governor of West Virginia for the ACS.

Fernando G. Giustini, M. D.

D. Verne McConnell, M. D.

Other speakers and their topics will be "Micro-Neurosurgery: A New Approach to Old Problems," Joseph C. Maroon, M. D., Assistant Professor in the Department of Neurological Surgery at the University of Pittsburgh School of Medicine and attending neurosurgeon at several Pittsburgh hospitals; "Present Concepts in the Evaluation and Personal Experiences in the Surgical Approach to the Patients with Stress Urinary Incontinence," Fernando G. Giustini, M. D., Wheeling obstetrician

and gynecologist, and "The Extremes of Plastic Surgery," D. Verne McConnell, M. D., also of Wheeling, plastic surgeon.

Also speaking will be Drs. Gerald Marks, Jefferson Medical School, Philadelphia; William P. Coghlan, Beaver Falls, Pennsylvania; Richard L. Slack, Point Pleasant; T. H. Chang, Philippi, and W. H. Bernie, Dayton, Ohio.

Four papers by surgical residents in West Virginia also will be presented.

State Medical Assn. To Join AMA In VD Symposium May 18

The American Medical Association will be joined by the West Virginia State Medical Association and other co-sponsors in presenting a "Symposium on Venereal Diseases" in Washington, D. C. on May 18 at the Shoreham Hotel from 9 A. M. to 5 P. M.

The other co-sponsors are the Medical Society of the District of Columbia, the Medical Society of Delaware, the Medical & Chirurgical Faculty of Maryland, the Pennsylvania Medical Society and the Medical Society of Virginia.

The Symposium will feature the scientific and clinical aspects of venereal diseases. It is being presented primarily for physicians, particularly those in the private practice of medicine, to assist them in the diagnosis and management of gonorrhea, syphilis and other sexually transmissible diseases. Medical students are particularly invited to attend.

Speakers and their topics at the morning session will be:

"The National Venereal Disease Problem"—Ralph H. Henderson, M. D., Chief, Venereal Disease Control Division, Center for Disease Control, Atlanta; "The Diagnosis and Treatment of Gonorrhea and its Complications"—Harry Pariser, M. D., Professor of Microbiology, Eastern Virginia Medical School, Norfolk; "The Management of Non-Gonococcal Urethritis"—William M. McCormack, M. D., Assistant Professor of Medicine, Harvard Medical Sschool, and "The Patient with a Vaginal Discharge"—Edwin J. DeCosta, M. D., Professor of Obstetrics and Gynecology, Northwestern University Medical School, Chicago.

The afternoon program will include "The Diagnosis and Treatment of Infectious Syphilis"—W. Christopher Duncan, M. D., Assistant Professor of Dermatology, Baylor University College of Medicine, Houston; "The Red, White, and Blue Lesions of the Genitals"—Nicholas J. Fiumara, M. D., Director, Division of Communicable and Venereal Diseases, Massachusetts Department of Public Health, Boston; "The Management of a Patient with a Positive Reagin Blood Test for Syphilis"—Arnold L. Schroeter, M. D., Assistant Professor in Dermatology, Mayo Clinic, and "The Other Sexually Transmissible Diseases"—Vernal G. Cave, M. D., Director, Bureau of Venereal Diseases Control, New York City Department of Health.

State Woman's Auxiliary To Meet In Bluefield April 24-25

The Woman's Auxiliary to the West Virginia State Medical Association will hold its Spring Board of Directors' Meeting and Workshop April 24 and 25 at the New Holiday Inn in Bluefield.

Membership will be discussed by the Auxiliary's special guest, Mrs. Norman H. Gardner of East Hampton, Connecticut. Mrs. Gardner is Eastern Regional Vice President of the Woman's Auxiliary to the American Medical Association, in charge of Membership.

Following registration on Wednesday, April 24, from 1 to 2 P. M., there will be a meeting of the Board of Directors, composed of state officers, state committee chairmen and component Auxiliary presidents. There will be a social hour beginning at 6:30 P. M. and a dinner at 8 P. M.

Thursday's schedule will begin with a Continental Breakfast at 9 A. M. followed by a workshop for all state and county officers and chairmen. The workshop will be under the direction of Mrs. William T. Lawson of Fairmont, President-Elect.

Mrs. J. Dennis Kugel of Charleston, President, said all Auxiliary members are invited to attend.

Delegates to the AMA Auxiliary meeting in Chicago in June will be elected at the Spring Board Meeting.

The Woman's Auxiliary to the Mercer County Medical Society will be in charge of arrangements.

Medical And Chirurgical Faculty In Baltimore April 17-19

The 176th Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland will be held April 17-19 at the Baltimore Civic Center.

General topics in the scientific program will include:

"What All Physicians Should Know About Ophthalmic Surgery," "Management of Tumors in Children," "Management of Soft Tissue Tumors and Sarcomas," "Wilms' Tumor and Neuroblastoma: Current Status," "Childhood Leukemia," "The Older Physician: Challenges and Problems,"

"Treatment of Metastatic Fractures Using Internal Fixation and Methylmethacrylate," "Renovascular Hypertension," "Clinical Aspects of Gastrointestinal Endoscopy," "Emergency Cardiac Care," "Type A Behavior Pattern: Number One Cause of Coronary Heart Disease?," "Clinical Value of Radionuclide Cerebral Perfusion Studies,"

"Prevention and Treatment of Deformities Following Burns," "Problems in the Anesthetic Management of Premature Infants," "Adult-Teenage Conflict: Problems of Communication," "Experimental, Clinical, and Radiological Aspects of Ischemic Intestinal Diseases," "Breast Reconstruction Following Surgery for Benign or Malignant Disease," "The Nurse Clinician in Industry," "Clinical Diagnosis and Management of Photosensitivity Diseases," "Clinical Applications of B-Scan Ultrasound."

Seminar In Emergency Medicine In Charleston May 10-11

A two-day Seminar in Emergency Medicine will be held by the Emergency Health Services Unit of the West Virginia Department of Health on May 10-11 at the Heart-O-Town Motor Inn in Charleston.

William H. Carter, M. D.

Geo. R. Callender, Jr., M. D.

Co-Sponsors will be the West Virginia State Medical Association, the Kanawha Medical Society and the State and Kanawha Chapters of the American Academy of Family Physicians.

Some nine Kanawha County physicians will participate in the program. Following registration beginning at 8:30 A.M., speakers and their topics for Friday morning, May 10, will be:

"Surgical Emergencies"—"Pulmonary Emergencies"—Dr. Dominic J. Gaziano and "Allergic Emergencies"—Dr. Joseph T. Skaggs.

The Friday afternoon program will include "Cardiac Emergencies"—Dr. William H. Carter; "Chest Emergencies"—Dr. Jamal Kahn, and "Pediatric Emergencies"—Dr. Thomas G. Potterfield.

There will be a cocktail party Friday evening beginning at 5 o'clock.

Saturday morning's program, following registration beginning at 8:30 A. M., will be:

"Neurosurgical Emergencies"—Dr. Carrel M. Caudill; "Orthopedic Emergencies"—Drs. George R. Callender, Jr., and Carl J. Roncaglione, and "Plastic Surgical Emergencies"—Dr. Jacques Charbonniez. A panel discussion will follow.

Head and Neck Anatomy Course Slated at East Carolina

The Fourth Postgraduate Course in Head and Neck Anatomy will be held at East Carolina University, at Greenville, North Carolina, May 28-31. The course is being sponsored by the Department of Anatomy of the School of Medicine in cooperation with the Division of Continuing Education.

For Additional information write: ECU Division of Continuing Education, P. O. Box 2727, Greenville, North Carolina 27834.

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled in the coming months.

1974

April 1-5—Am. Coll. of Rad., New Orleans.
April 5-7—W. Va. Chapter, AAFP, Charleston.
April 7-12—Am. Assn. Immunologists, Atlantic City.
April 8-11—S.E. Surgical Congress, Atlanta.
April 10-13—Tenn. Med. Assn., Gatlinburg.
April 17-19—Maryland Medical, Baltimore.
April 17-20—W. Va. Acad. of Ophth. and Otol., White Sulphur Springs.
April 20-25—Am. Assn. of Neur. Surg., St. Louis.
April 22-24—Am. Assn. Thoracic Surgery, Las Vegas.
April 22-25—Am. Acad. Pediatrics, Bal Harbour, Fla.
April 22-27—Am. Acad. of Neur., San Francisco.
April 26—WVU Med. Student Research Convo., Morg.
April 29-May 2—Am. Coll. Ob.—Gyn., Las Vegas.

May 1-3—Am. Surg. Assn., Colorado Springs.
May 1-4—W. Va. Chapter, ACS, White Sulphur Springs.
May 10-11—Sem. In Emerg. Med., Charleston.
May 12-15—Am. Thoracic Soc., Cincy.
May 12-15—S. Carolina Med. Assn., Myrtle Beach.
May 12-15—Ohio State Med. Assn., Cleveland.
May 12-16—Am. Assn. Plastic Surgeons, Seattle.
May 16-18—Childhood Cancer, Dallas.
May 17-18—Am. Assn. Clin. Urologists, St. Louis.
May 18—Symp. On V.D., Wash., D.C.
May 19-22—Am. Ophthal. Soc., Hot Springs, Va.

June 3-6—Int. Convo. Immunology, Buffalo, N. Y.
June 10-12—Am. Neuro. Assn., Boston.
June 15-16—Am. Diabetes Assn., Atlanta.
June 22-23—Am. Assn. Study of Headache, Chicago.
June 23-27—AMA, Chicago.
June 24-26—Am. Coll. Preventive Med., Chicago.

July 25-27—Am. Electroencephalographic Soc., Seattle.
July 28-Aug. 1—Natl. Med. Assn., N. Orleans.
July 28-Aug. 2—Int. Assn. Child Psychiatry & Allied Professions, Phila.

Aug. 12-15—Am. Hosp. Assn., Chicago.
Aug. 21-24—107th Annual Meeting, W. Va. State Medical Assn., White Sulphur Springs.

Sept. 4-7—Am. Assn. Ob.-Gyn., Hot Springs, Va.
Sept. 16-19—Ky. Med. Assn., Louisville.
Sept. 18-21—Am. Thyroid Assn., St. Louis.

Oct. 6-10—Am. Acad. Oph. & Otol., Dallas.
Oct. 14-17—AAFP, L. A.
Oct. 19-24—Am. Acad. Pediatrics, San Fran.
Oct. 21-25—ACS Clinical, Miami Beach.

1975

Jan. 24-26—8th Annual Mid-Winter Clinical Conf., Charleston.

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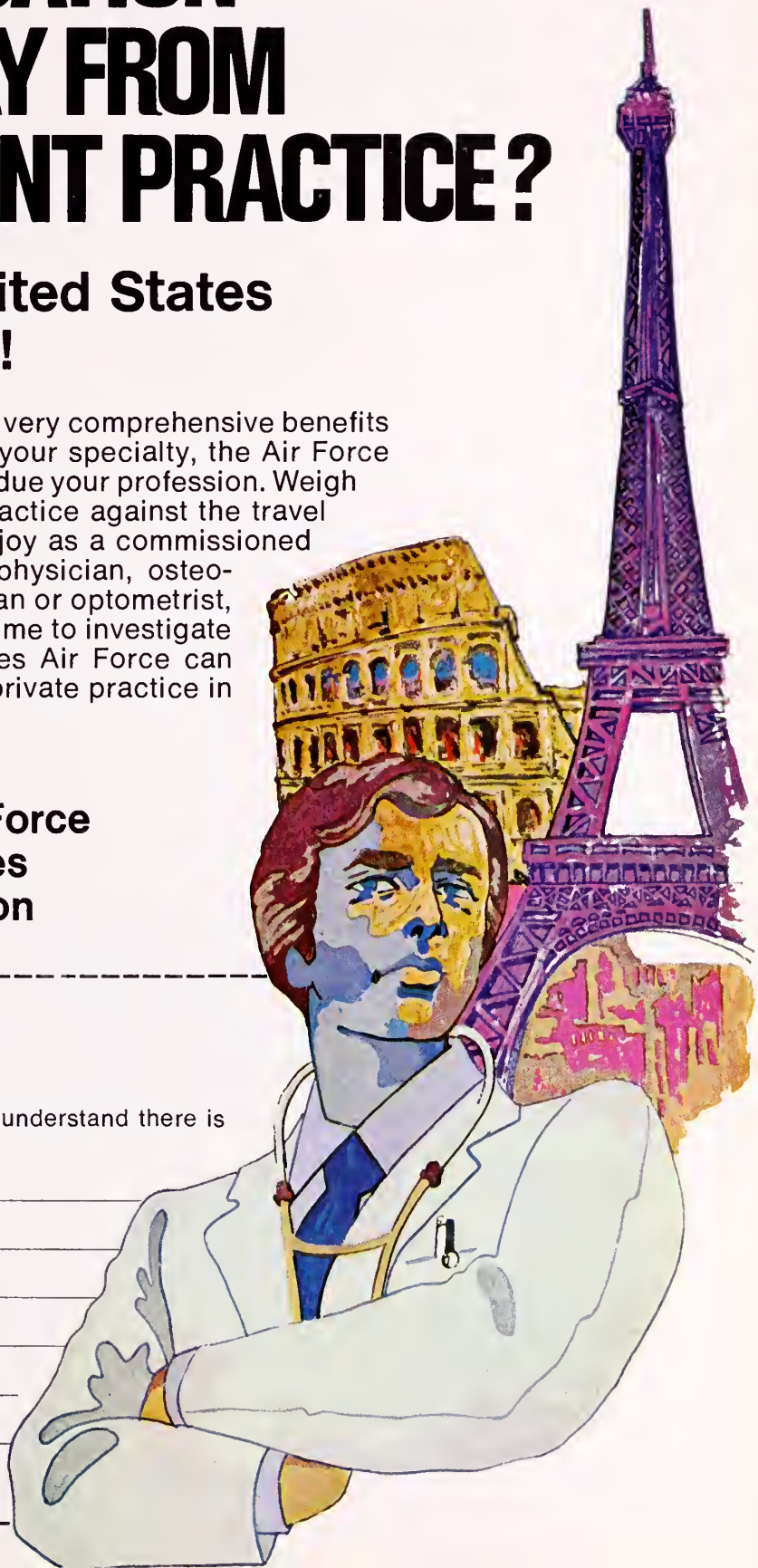

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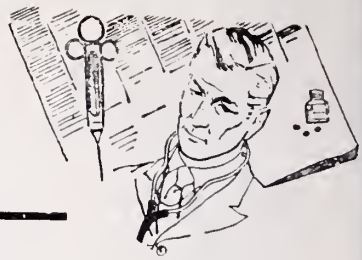

• **Compiled from material furnished by Mrs. Mary Ellin Wylie, Director, Medical Center News and Information Services, Morgantown, W. Va.**

THE Ninth Annual West Virginia University Medical Student Research Convocation will be held on April 26 in the Medical Center Auditorium from 2 to 5 P. M.

Medical students will present the results of their research to fellow students, faculty and practitioners. The reports will be judged by a committee and the E. J. Van Liere Medal plus a cash prize will be awarded for the most outstanding presentation. Cash prizes will be awarded also for second and third places. All physicians are cordially invited to attend.

Three Physicians Honored

Three physicians have gained additional national recognition for West Virginia University School of Medicine's Department of Behavioral Medicine and Psychiatry by being selected for coveted fellowships.

Only 20 Falk Fellowships are granted each year by the American Psychiatric Association, and two of these are held at WVU. They are given to second-year residents who show leadership ability and administrative skill. Recipients at WVU are Dr. James Stevenson, who has received one for the second consecutive year, and Dr. Taylor Fithian.

Every other year, the Group for the Advancement of Psychiatry, Inc., gives Sol W. Ginsburg Fellowships to 20 of the nation's 4,000 to 5,000 residents in psychiatry. The awards are in recognition of academic achievement.

Named a Ginsburg Fellow at WVU is Dr. Charles F. Marsh, a resident in child psychiatry.

Eleven physicians are receiving residency training in behavioral medicine and psychiatry at WVU. Only two other psychiatry programs in the United States, both with 50 to 75 residents, have as many as three recipients of these fellowships.

Appointment System Initiated

West Virginia University's Health Service recently went into its newest phase of operation when it initiated an appointment system.

The Health Service is located on the fourth floor of WVU Medical Center.

By telephoning 293-2311, university students, faculty and staff members may make appointments to be seen anytime between 8:30 A. M. and 5 P. M. (including the noon hour), Mondays through Fridays, except 12:30 to 1:30 P. M. on Thursdays.

Dr. Roger L. McCauley, Assistant Medical Director, said, "Appointments will enable patients to see the physicians they choose and also will eliminate lengthy waits. The system will make it easier for students to use the Health Service during their free hours such as between classes and during the lunch hour." He said he expects the system initially to absorb 50 per cent of the patient load and eventually account for 75 per cent, or more, of the volume. "We hope it will be well under way when we move in the spring to our new headquarters on the ground floor of the Medical Center," Doctor McCauley added.

Since moving to the Medical Center in August 1971, the Health Service has added specialty care in nine areas: gynecology, dermatology, allergy, public health, endocrinology, infectious diseases, urology, cardiopulmonary medicine, and behavioral medicine and psychiatry. These services all are available on an appointment basis.

Service for students requiring acute care will continue on a nonappointment basis from 5 to 8 P. M., Mondays through Fridays, as well as 9 A. M. to noon, Saturdays and Sundays, when one physician is on duty.

Research Grants Announced

The WVU Medical Center has received several research grants in recent months. The grants, and the WVU physician in charge, are as follow:

National Cancer Institute, $85,166, to continue research on the actions of pituitary hormones and androgens on prostate gland metabolism, Dr. John Thomas;

National Institute of Neurological Diseases and Stroke, $59,060, to continue research on the mechanism of nonspecific supersensitivity to drugs, Dr. William W. Fleming;

National Science Foundation, $45,100, for research on hormonal interactions in the regulation of steroid secretion by the adrenal cortex, Dr. Howard D. Colby;

National Institute of Arthritis, Metabolism and Digestive Diseases, $26,093, to continue research on blood fats and diabetic complications, Dr. Margaret J. Albrink;

Bristol Laboratories, $12,450, for study of sodium cloxacillin for injection, Dr. Albert S. Klainer.

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The Month in Washington

• **From the Washington Office of the American Medical Association.**

THE American Medical Association has announced the filing of a law suit against the Cost of Living Council to seek an end to all economic controls on medicine.

At a news conference in the AMA-Washington Office, the organization disclosed that it is seeking an injunction against the Phase IV regulations on physicians and hospitals. It charged that the rules are "confiscatory, arbitrary and capricious," that they violate the "generally fair and equitable" standard established by Congress and that they violate the fifth amendment of the U. S. Constitution.

Announcement of the legal action was made by Russell B. Roth, M. D., President of the AMA, and James H. Sammons, M. D., Chairman of the AMA Board of Trustees.

In its complaint stating its legal action, the AMA pointed out that the Phase IV regulations represent an "attempt to mold the health care delivery system to comport with the CLC's concepts for health care" and are specifically designed "to curb the quantity and quality of health care services as an integral part of the legislative program to induce Congress to enact national health insurance."

The AMA asked that the court declare these Phase IV regulations invalid and enjoin the Cost of Living Council from enforcing them.

In his statement, Doctor Roth said the AMA was filing in U. S. District Court, District of Columbia, a suit seeking an injunction against the Cost of Living Council. "We are asking the court to declare invalid the Phase Four regulations as applied to physicians and hospitals on the grounds that they are confiscatory, arbitrary, capricious and discriminatory.

"We further believe that they violate the very law on which they are based in that they do not conform to the 'generally fair and equitable' standard written into the law by the Congress.

"Finally, we believe that they violate the most fundamental law of the land—the Constitution of the United States in that they confiscate the property of physicians and hospitals without due process of law, a clear infringement of the fifth amendment.

"Those are the legal tenets on which we are basing our case. We are convinced that they are valid and sound and that they will prevail in the courts.

"But while we proceed on legal grounds, I think it is important to point out that we believe the issues involved are far broader than mere legalisms and that they cast their shadows far beyond the limited scope of Phase IV.

"They are issues of principle and they have profound implications for the future of health care in this country.

"—It is patently unfair and unreasonable for the services of some working people—namely us physicians—to be subject to severe price controls while permitting other working people to function in a free market. That is not fair play; it is an act of discrimination.

"It is patently unfair to apply a revenue margin limitation to physicians in private practice so that they are penalized if they work longer hours and see more patients. That is not fair play; it is an act of capriciousness—not to mention that it is also short-sighted as hell.

"It is patently unfair when physicians are subject to controls but chiropractors and naturopaths are not . . . when ophthalmologists are subject to controls but optometrists and opticians are not . . . when psychiatrists are subject to controls but clinical psychologists and psychiatric social workers are not. That is not fair play; rather it is an act so arbitrary as to be vindictive.

"Any one of these would be good and sufficient reason to end the controls, in and of itself. For a law that is applied arbitrarily, capriciously and vindictively is a bad law and ought to be abolished.

"But there are even more compelling reasons why the controls should be abolished—not just from health care but from the entire economy.

"Perhaps the best reason for getting rid of them is that they just don't work—."

Doctor Sammons' statement noted that the AMA did not stand alone in its call for an end to all controls. "No less a person than C. Jackson Grayson—Chairman of the Price Commission during Phase II—has adopted the same stance," Doctor Sammons said, adding "he has been echoed by the Wall Street Journal and others."

"In the face of this advice and the evidence that controls don't work, why does the Cost of Living Council persist in continuing the controls?

"CLC officials have made no secret of the fact that they intend to control far more than costs in the health care field through their regulations.

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Obituaries

A. MORGAN DEARMAN, M. D.

Dr. A. Morgan Dearman, who specialized in gynecology and obstetrics in Parkersburg, died on February 5 in a hospital there. He was 76. A past President of the West Virginia Obstetrics and Gynecology Society, Doctor Dearman had served on the staffs at Camden-Clark Memorial and St. Joseph's hospitals in Parkersburg until he retired in 1971 after 50 years in practice.

Born at Zona, in Roane County, he attended Valparaiso (Indiana) University and West Virginia University. He received his M. D. degree in 1921 from the University of Louisville School of Medicine and did graduate and postgraduate work in New York City hospitals.

Doctor Dearman practiced for five years in Smithville, in Ritchie County, before going to Parkersburg. He was a member and past Vice President of the Parkersburg Academy of Medicine. He also was a member of the American Medical Editors and Authors Association, the West Virginia State Medical Association and the American Medical Association.

Surviving are a son, A. Eugene Dearman of Springfield, Ohio; a brother, Austin E. Dearman of Parkersburg, and a sister, Delphia Wilson of Boulder, Colorado.

* * * *

MALCOLM G. MacAULAY, M. D.

Dr. Malcolm G. MacAulay, a Beckley psychiatrist, was dead on arrival at a Beckley hospital on March 3 after suffering an apparent heart attack at his home. He was 47.

From 1959 through 1964 Doctor MacAulay was associated with the Beckley Mental Health Center and from 1964 through 1966 he was Director of the Charleston Health Center. He served on the staff of St. Albans Hospital in Radford, Virginia from 1966 to 1969.

A native of East Angus, Quebec, Canada, Doctor MacAulay received his M. D. degree in 1949 from McGill University in Montreal, Canada. He interned at St. Luke's Hospital in Newburgh, New York and served a residency in psychiatry at Walter Reed General Hospital in Washington, D. C. He served for six years with the U. S. Army Medical Corps during the Korean War.

Doctor MacAulay was a member of the Raleigh County Medical Society, the West Virginia State Medical Association, the American Medical Association and the American Psychiatric Association.

Survivors include the widow, four sons, Jeffrey MacAulay of Beacon, New York, and Thomas, Brian and Gerald MacAulay, at home; two daughters, Marilyn MacAulay, a student at Virginia Polytechnic Institute in Blacksburg, Virginia, and Jacqueline MacAulay, at home; a sister, Mrs. Dawn Broughton of Canada, and a brother, Gordon MacAulay of Canada.

* * * *

W. S. ROWAN, M. D.

Dr. W. S. Rowan, a Logan physician since 1916, died on February 18 in a hospital there. He was 83.

Doctor Rowan received his M. D. degree in 1914 from the University of Louisville School of Medicine. A World War I veteran, he practiced two years in Mercer County before going to Logan. He was still practicing at the time of his death.

Doctor Rowan was a member of the Logan County Medical Society and the West Virginia State Medical Association.

Surviving is a sister, Mrs. Bess Johnston of Princeton.

* * * *

FRANCIS A. SCOTT, M. D.

Dr. Francis A. Scott, Huntington orthopedic surgeon and founder of the Scott Lecture Series at Marshall University, died on February 21 at his home following an extended illness.

Doctor Scott, who was a founding member of the Tri-State Orthopedic Society, retired from practice in 1966. He was a Past President of the Cabell County Medical Society and had been a Huntington resident since 1929.

A native of Washington, Michigan, he was a graduate of the University of Michigan and received his M. D. degree in 1925 from that institution's Medical School.

He was a member of the American College of Surgeons, the American Academy of Orthopedic Surgeons, and was a Diplomate of the American Board of Orthopedic Surgery. He also was an honorary member of the Cabell County Medical Society, the West Virginia State Medical Association and the American Medical Association.

The first Scott Lecture was held in 1957. Doctor Scott maintained a personal and professional relationship with Marshall University for more than two decades, and for many years cared for injured Marshall athletes.

He was a major donor to Marshall's honors program, and established a scholarship program for pre-medical students. In recognition of his contributions to Marshall, he was awarded an honorary Doctor of Humane Letters Degree by the University in 1967.

Doctor Scott also was recognized for his many contributions to the State Medical Association over the years.

He served in the Medical Corps of the U. S. Navy during World War II and served in the South Pacific. He was discharged with the rank of Captain.

Survivors include the widow, and two sons, Dr. Thomas F. Scott of Huntington and James E. Scott of Amherst, Massachusetts.

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County Societies

FAYETTE

The Fayette County Medical Society met on February 13 at Oak Hill Hospital in Oak Hill. The guest speaker was Dr. Hartwell G. Thompson, Dean of the Charleston Division of the West Virginia University School of Medicine.

Doctor Thompson spoke of the relationship of the Charleston Area Medical Center to southern West Virginia and how its many programs may better serve Fayette County as well as the southern part of the state.

It was announced that the guest speaker for the March meeting would be Dr. Marshall J. Carper of Charleston.—Carl R. Adkins, M. D., Secretary.

* * * *

McDOWELL

The McDowell County Medical Society met on February 13 at the Stevens Clinic Hospital in Welch.

It was reported that a check had been sent by the Society to *The West Virginia Medical Journal* to pay for The Journal for students from this area attending the West Virginia University School of Medicine.

A letter from the American Medical Association was read to the membership. It stated the AMA's position in filing suit to prevent the implementation of proposed regulations requiring preadmission certification of elective hospital admissions for Medicare and Medicaid recipients—A. A. Carr, M. D., Secretary.

* * * *

MERCER

The Mercer County Medical Society met on February 18 at the University Club in Bluefield. Dr. N. Allen Dyer of Bluefield presented a movie showing services provided by the Southern West Virginia Health Council. Doctor Dyer said the present program of the Council is still funded by contracts with State and local agencies. He also discussed the reorganization and realignment of the Council on a fee for service basis, and answered questions concerning the Speech Clinic, screening of welfare children and the Family Planning Program.

The West Virginia Medical Institute was discussed and Society members were urged to join.—John J. Mahood, M. D., Secretary.

* * * *

MONONGALIA

Dr. Stanley J. Kandzari spoke at the meeting of the Monongalia County Medical Society on February 5 at the International Club in Morgantown. Doctor Kandzari, Assistant Professor of Urology at the West Virginia University School of Medicine, discussed "Tumors of the Upper Urinary Tract."

Doctor C. A. Logue reported on the American

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R. V. Pangilinan, M. D.

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Thoracic Surgery:
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COUNTY SOCIETIES—(Continued)

Medical Association National Leadership Conference in Chicago in January.

The Society approved a donation of $155 to sponsor one handicapped child for two weeks at Camp Horseshoe in Parsons.—H. Summers Harrison, M. D., Secretary.

AMA/AAMA Accreditation Is Given Governmental Recognition

The Council on Medical Education of the American Medical Association, in collaboration with the American Association of Medical Assistants, has been recognized by the U. S. Commissioner of Education as an official agency to accredit educational programs for the medical assistant. AMA and AAMA have collaborated on the accreditation of medical assisting programs since July 1969, when curriculum standards were approved by the AMA House of Delegates. To date 58 one- and two-year programs have been approved in junior and community colleges and proprietary schools.

Emergency Health Care Seminar In Kentucky May 30-31

The "1974 Emergency Health Care Seminar" will be held in Louisville, Kentucky on May 30-31 by the Kentucky Medical Association. The Seminar will be held at the Ramada Inn-Bluegrass Convention Center in Louisville.

Topics will include "Ophthalmologic Emergencies," "Venomous Stings and Bites," "Burns," "Tetanus," "The Unconscious Patient," "Cardiopulmonary Resuscitation," "Behavioral Emergency," "Head and Facial Trauma," "Urologic Emergencies," "Pediatric Surgical and Medical Emergencies" and "Extremity Injuries."

The registration fee will be $10 per registrant per day. The Seminar is acceptable for 13 and one-half hours of credit in Category 1 of the Physician's Recognition Award of the American Medical Association.

For further information contact Kentucky Medical Association at 3532 Ephraim McDowell Drive, Louisville 40205.

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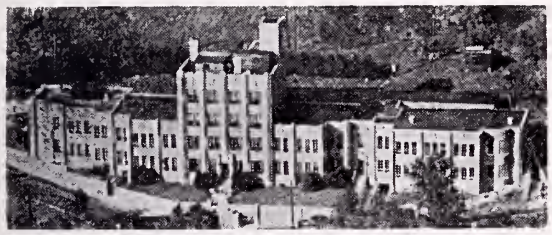
OFFICERS OF COMPONENT SOCIETIES

Society	President		Secretary		Meetings
Boone	George H. Cook	Whitesville	Harold H. Howell	Madison	3rd Wed.
Brooke	John W. Traubert	Wellsburg	James E. Wise	Follansbee	
Cabell	E. J. Humphrey, III	Huntington	C. H. McKown, Jr.	Huntington	2nd Thurs.
Central West Virginia	I. Frank Hartman, II	Buckhannon	Joseph B. Reed	Buckhannon	As Sched.
Eastern Panhandle	Hiram Sizemore, Jr.	Shepherdstown	Everett S. Fagle	Martinsburg	2nd Wed.
Fayette	A. R. Bautista	Montgomery	Carl R. Adkins	Fayetteville	1st Wed.
Greenbrier Valley	Lee B. Todd	Quinwood	Herbert L. Pope	Wht. Sul. Springs	2nd Wed.
Hancock	Dominic A. Brancazia	Weirton	James M. Garvey	Weirton	3rd Tues.
Harrison	Robert D. Hess	Bridgeport	Roy A. Harran	Bridgeport	1st Thurs.
Kanawha	John B. Markey	Charleston	Joseph T. Skaggs	Charleston	2nd Tues
Logan	Mark S. Spurlock	Logan	Jorge J. San Pedro	Man	2nd Wed
Marion	E. F. Hyde, Jr.	Fairmont	John L. Cayner	Fairmont	Last Tues.
Marshall	Andrew J. Barger	Glen Dale	Michail Dalgavskij	Glen Dale	3rd Tues.
Mason	Aarom Boonsue	Pt. Pleasant	Anthony G. Sala	Pt. Pleasant	4th Tues
McDowell	Mario S. Cardona	Welch	A. A. Carr	Welch	2nd Wed.
Mercer	Hawey A. Wells, Jr.	Princeton	John J. Mahaad	Bluefield	3rd Man.
Minga	Charles H. Bruce	Williamson	Wm. H. Carter	Williamson	2nd Wed.
Monongalia	W. Gene Klingberg	Morgantown	H. Summers Harrison	Morgantown	1st Tues.
Ohio	Joseph N. Aceta	Wheeling	Edward C. Voss, Jr.	Wheeling	4th Tues
Parkersburg Academy	R. J. Bailey	Parkersburg	Paul G. Madie, Jr.	Parkersburg	1st Thurs.
Potomac Valley	Estevan Friera	Romney	Carl A. Liebig	Keyser	2nd Wed
Preston	Donald P. Brown	Kingwood	C. Y. Moser	Kingwood	4th Thurs.
Raleigh	Eugene Warvariv	Daniels	C. W. Nelson, Jr.	Beckley	3rd Thurs.
Summers	Davis Wm. Ritter	Hinton	James Wm. Stokes	Hinton	3rd Mon.
Tygart's Valley	Robert R. Rector	Elkins	A. Kyle Bush	Philippi	3rd Thurs.
Wetzel	Lemayne Caffield	N. Martinsville	Charles P. Watson	N. Martinsville	Monthly
Wyoming	Solomon D. Reodica	Mullens	Jose Floresca	Mullens	Quarterly



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Fulvio Franyutti, M. D.

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A. Kyle Bush, M. D.
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AMA Offers Timely Suggestions As Boating Season Begins

Small boats by the hundreds of thousands are back in the water this month, freshly scraped and painted after a winter of storage.

In the deep South boating fans are on the water most of the Winter, but in most of the nation May is the season to get back on the lakes and streams.

The American Medical Association reminds that boating accidents become more prevalent each season, as more neophytes acquire boats and take to the water. Pamphlets on boating safety are available in many sporting goods stores and at boat and motor dealers and marinas, and through the U. S. Coast Guard. Even if you think you know how to handle a boat, play it safe. Get a safety booklet and study it.

Common sense and good manners are the cardinal safety rules in boating. Show respect for other boats, swimmers and fishermen. It doesn't take much knowledge of boating to know that a big lake on a windy day can be dangerous for small craft.

Know the capacity of your boat and don't overload it. Don't stand up or change seats in a small craft while it is under way.

Make certain your boat contains life preservers for each passenger. Life jackets should be worn by small children and non-swimmers. Know the Federal and State regulations governing registration and operation of your boat.

Only an irresponsible skipper will buzz a dock, wharf or anchored craft. You may miss. Reduce speed through anchorages. Your wake can damage other property. Avoid boating too close to water skiers, fishermen and other boats. Don't jump or dive from a moving boat. You may have the breath knocked out of you, or hit floating debris.

Stay within easy range of the shore on large bodies of water. Sudden squalls can play havoc with the unwary boatsman. If your boat overturns, stay with it. The chances are that someone will pick you up. Very few of us are in good enough physical condition for a long swim in rough or cold water.

Health Care in Jails and Prisons

A planning committee has been named for the American Medical Association program aimed at improving health care in jails and prisons. Dr. Paul W. Burleson of Birmingham, Alabama, heads the panel. In a national survey conducted with the American Bar Association, the AMA found that medical care is non-existent in many jails and seriously inadequate in others.

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Members of the West Virginia State Medical Association are requested to notify the headquarters offices promptly concerning any change in address. Notices should be mailed to Box 1031, Charleston, West Virginia 25324.

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WANTED—Full-time Public Health Physician for Cabell-Huntington Health Department, Huntington, West Virginia. Opening available immediately. Contact Mr. Ernest Leaberry, President, 1336 16th Street, Huntington, W. Va. 25701.

PHYSICIAN'S PRACTICE FOR SALE — Well-equipped office of recently deceased physician is for sale and would be a most attractive opportunity for a family physician. Three treatment rooms plus a laboratory. Contact Mrs. Frank M. Muldoon, Salem, W. Va. 26426.

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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal a be associated with temporary increase in frequency and/or seve y of seizures. Advise against simu taneous ingestion of alcohol and other CNS depressants. Withdra a symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt disco tinuance (convulsions, tremor, al dominal and muscle cramps, vomi n and sweating). Keep addiction-pr e individuals under careful survei lance because of their predisposi n to habituation and dependence. I pregnancy, lactation or women o childbearing age, weigh potential benefit against possible hazard.

When you determine that the pressive symptoms are associated th or secondary to predominant xiety in the psychoneurotic tient, consider Valium (diazepam) addition to reassurance and unseling, for the psychotherapeutic pport it provides. As anxiety is lieved, the depressive symptoms ferable to it are also often relieved reduced.

The beneficial effect of Valium is ually pronounced and rapid. nprovement generally becomes ident within a few days, although some patients may require a longer period. Moreover, Valium (diazepam) is generally well tolerated. Side effects most commonly reported are drowsiness, ataxia and fatigue. Caution your patients against engaging in hazardous occupations or driving.

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recautions: If combined with psychotropics or anticonvul- consider carefully pharma- of agents employed; drugs s phenothiazines, narcotics, turates, MAO inhibitors and antidepressants may poten- ts action. Usual precautions ted in patients severely de- ed, or with latent depression, h suicidal tendencies. Observe precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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1974

Vol. 70 No. 5

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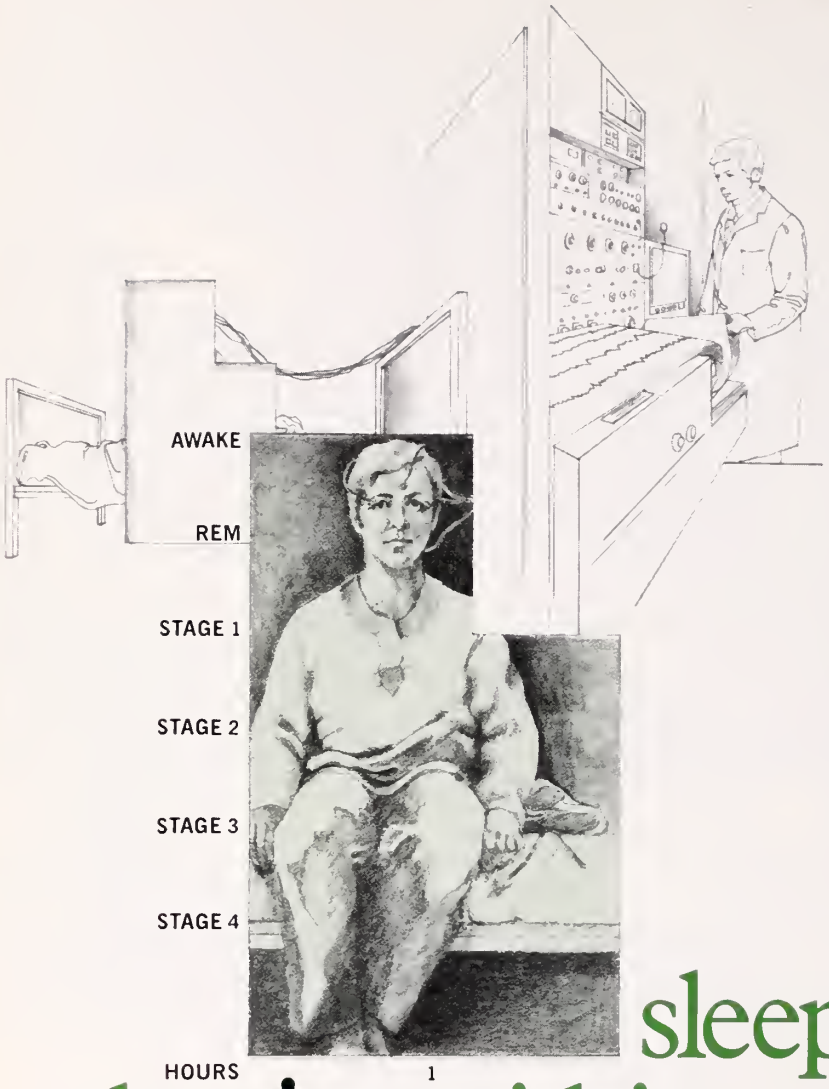

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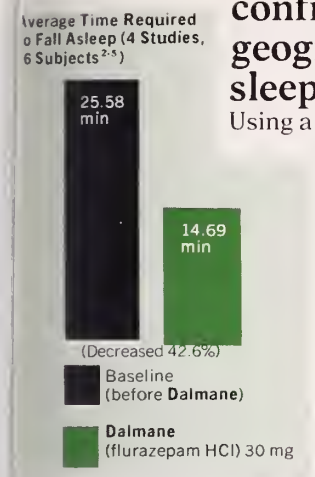

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recautions: In elderly and debilitated, initial dosage should be mited to 15 mg to preclude oversedation, dizziness and/or ataxia. combined with other drugs having hypnotic or CNS-depressant fects, consider potential additive effects. Employ usual precautions n patients who are severely depressed, or with latent depression or uicidal tendencies. Periodic blood counts and liver and kidney unction tests are advised during repeated therapy. Observe usual recautions in presence of impaired renal or hepatic function.

dverse Reactions: Dizziness, drowsiness, lightheadedness, taggering, ataxia and falling have occurred, particularly in elderly r debilitated patients. Severe sedation, lethargy, disorientation and oma, probably indicative of drug intolerance or overdosage, have een reported. Also reported were headache, heartburn, upset tomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousess, talkativeness, apprehension, irritability, weakness, palpitations, hest pains, body and joint pains and GU complaints. There have lso been rare occurrences of sweating, flushes, difficulty in focusing, lurred vision, burning eyes, faintness, hypotension, shortness of reath, pruritus, skin rash, dry mouth, bitter taste, excessive salivaion, anorexia, euphoria, depression, slurred speech, confusion, estlessness, hallucinations, and elevated SGOT, SGPT, total and irect bilirubins and alkaline phosphatase. Paradoxical reactions, .g., excitement, stimulation and hyperactivity, have also been eported in rare instances.

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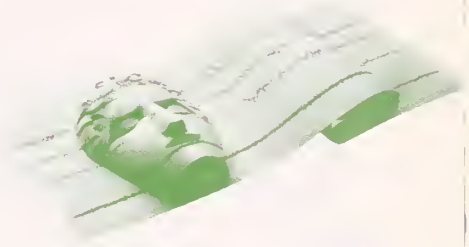

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EFERENCES: 1. Kales A, *et al: Arch Gen Psychiatry 23*:226-232, Sep 1970
. Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and leep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington DC, May 3-7, 1971
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Opinion & Dialogue

Is there a need for a drug compendium?

Government Health Official

Henry E. Simmons, M.D.
Deputy Assistant Secretary for Health
Department of Health, Education and Welfare

A drug compen of the type I envis would fill a definite need for the pra ing physician. S compendium v give him al information c essary for u a drug intelligently, and it wou do so in a clear, concise, convenient, objective and balance fashion.

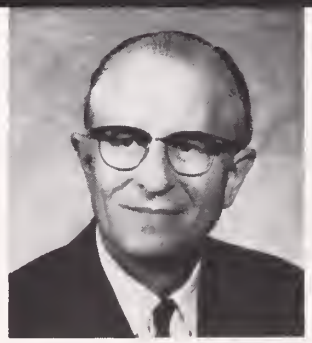
What a Compendium Should Contain

I believe the compendiur should inform the doctor what drug will do, when he should u for what type of patient, for ho long, in what dose, what benef his patient is likely to obtain, tl risks involved, and cross-react with other drugs.

The information would be based on the package insert ar have the same legal status. In t a complete compendium with plete and current information might even eliminate the nece

Maker of Medicine

Joseph F. Sadusk, Jr., M.D.
Warner-Lambert Company



A drug compendium, or preferably compendia, should believe, be private, not federal sponsorship. They should cont comprehensive listings of drug available for prescribing. They should be single, legibly printe volumes of reasonable size, up dated quarterly or semiannuall and completely revised every y

Function of a Compendium

A compendium should fu nish the following information drugs in the following order: inc tions for use, side effects, adve drug reactions, contraindicatic drug interactions, drug dosage the dosage forms marketed. Dr prices should not be included b cause they vary so widely and change rapidly.

No compendium should s forth drugs of choice or discus relative efficacy. Such questior must be left for the practicing p sician to decide, whether on th basis of the medical literature, s own clinical experience, advice f colleagues, information supplie by manufacturers, and so on.

Nor should a compendiur undertake to educate the docto how to use drugs. Rather, it mu be a reference source designec marily to refresh his memory a drugs he may not use regularly

package insert in many in-
ces. This would constitute a
stantial saving for the manu-
urer.

By a complete compendium,
not mean a volume of prohibi-
size. You don't need a book
cribing 25,000 products with
normous amount of repetition.
her, drugs should be arranged
lass. Mutually applicable infor-
ion would be provided, along
brief discussions pinpointing
erences in specific drugs of
class. Listings would be cross-
xed in a useful way.

er Available Documents as rces of Information

Existing references such as
R and the AMA Drug Evaluation
obviously useful but they are
omplete. Either they are not
ss-referenced by generic name
do not group drugs with simi-
characteristics, or they do not
all the available and legally
keted drugs. And some of
se omitted may be very useful.

On the other hand, drugs made by more than one supplier, tetracycline for example, may be fully described a dozen times in the same book.

While perhaps PDR could be rearranged and cross-indexed with generics included, and while the AMA Drug Evaluation might also be modified and expanded, I am not sure that the end result would have all the attributes required for a useful compendium. At the same time, you would run the risk of amassing a voluminous and unwieldy tome.

Should Editorial Comments Accompany the Listings?

Subjective judgments, in my opinion, have no place in a compendium. However, if there is substantial evidence based on a sound body of science concerning relative efficacy of several drugs, certainly that information should be included. The committee of experts compiling and editing a particular section would also have to assess and indicate instances where a meaningful difference between drugs is pertinent.

Sponsorship, Compilation and Editing

Producing a book like this would undoubtedly be difficult and demanding. It would obviously take a great deal of talent and expertise, and would require a varied and experienced group, ranging from writers and editors to highly skilled clinicians and pharmacologists. Style, format and clarity of language would play an important part in determining the usefulness of the book. And it should be updated periodically and completely revised annually.

I have no opinion whether the government or the private sector should sponsor and/or finance the compendium. What is most important is that the compendium be an authoritative, objective and useful source of information for the doctor to have at hand as a ready reference.

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uld in no way imply control over
practitioner's prerogatives.

y Another Compendium?

A practicable, single-volume
mpendium cannot, nor is it
cessary to, include all drugs on
market today. From my prac-
e of internal medicine for some
years, my experience as a con-
tant, and as a faculty member
our or five medical schools, I
uld estimate that a doctor uses
y 30 to 35 drugs regularly. The
72 Physicians' Desk Reference,
identally, contained about
00 entries.

As to whether there should be
ederal compendium, in my opin-
, as stated earlier, the answer is
sy—there should *not* be one. The
posal assumes that existing
mpendia are inadequate. We're
t sure of that at all. Whatever its
perfections, the present drug
ormation system in the U.S. is
en, multifaceted, pluralistic and
tensive. Good compendia exist,
well as other ample sources on
ug therapy, ranging from journal
erature through AMA Drug Evalu-
ion to company materials. Not
physicians may use such
urces as often or as well as they
ould, but that is the fault of the
an, not of the sources.

In any event, rather than produce another book, it makes much more sense to work on improving existing compendia, and perhaps they could, as knowledge advances, include more accumulated clinical data and experience, and more information on drug interactions and adverse reactions.

Implications of a Federal Compendium

Take a hard look at the implications of a federal compendium. It would have the force of law, virtually dictating what drugs to use and how to use them. In effect, it would be a regulatory document with legal or quasi-legal status, posing medical/legal problems similar to those the doctor may now encounter if and when he departs from the provisions of the package insert. A compendium under federal aegis would tend to restrict decisions on drug therapy to one orthodox level—a most dangerous trend for medicine.

New Compendium—A Medical Option

I detect no ground swell of initiative or support whatsoever for a federal compendium—or, for that matter, for a new compendium of any type. A 1969 PMA survey conducted by Opinion Research Corporation found that only 15 per cent of those physicians interviewed felt a new compendium was needed. And a large majority did not favor the involvement of the federal government if one were to be created, preferring instead a nongovernmental consortium.

Even if we come to a time when the medical profession itself opts for a new kind of compendium, it should be handled and financed, ideally, outside both government and industry. Final review and editorial authority could be delegated, say, to specialty bodies and medical societies—but above all, *not* the government.

Surely the health care system in the United States has far more vital matters to consider than the extensive cost and effort that would have to go into the preparation and maintenance of a new, monolithic compendium, and especially one bearing the imprimatur of the federal government.

Opinion & Dialogue

What is your opinion, doctor? We would welcome your comments.

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We are faced with these facts: only 53% of women over 20 have ever had a Pap test; only 20% get a Pap test periodically; each year about 43,000 new cases are diagnosed; this year 12,000 women in this country will die of uterine cancer. And about 75% of these deaths will result from cervical cancer—as you know, almost 100% curable when diagnosed early and treated promptly.

We hope to reach women in the target group not only with the message about the *vital* Pap test, but also with the urgency of including it in the *regular* health checkup. The mortality rate from uterine cancer could thus be dramatically curtailed.

Clearly action is called for. Coordinated action—involving the doctor, the patient, the American Cancer Society—a partnership for life.

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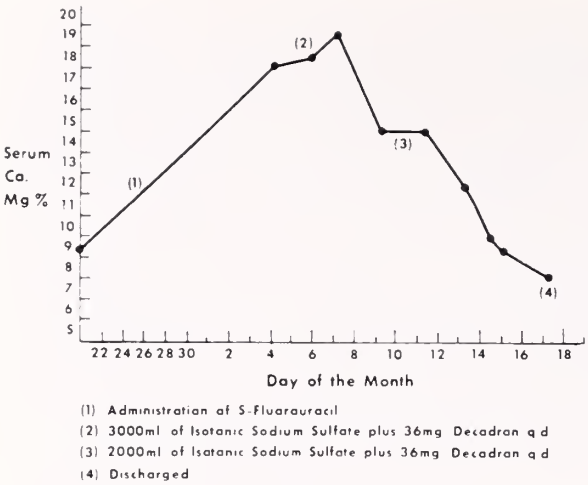

Figure 1.

mon cause of a high serum calcium is bone destruction by metastasis. Less common causes are the elaboration of parahormone-like polypeptides and, by recent experimental evidence, a Vitamin D-like substance.[2] In the normal subject, the calcium balance is maintained, and the serum calcium is constant with only mild variation range. The maintenance of this narrow range depends upon the inner relationships of parahormone, calcitonin and the ionized serum calcium. Other ions and the serum protein also contribute to this balance. The metabolism of calcium is a complex subject and beyond the scope of this paper.

Manifestations of hypercalcemia are related to calcium stabilizing effects on the cell membrane. The excitability of nerve tissue and the contraction of smooth, skeletal and cardiac muscles are profoundly affected by the extracellular levels of ionized serum calcium. Hypercalcemia affects the kidney by decreasing glomerular filtration rate, thereby lowering the excretion of calcium and further aggravating the hypercalcemia. In the clinical setting this would present as a progressive azotemia and renal insufficiency. Hypercalcemia also caused a decrease in the ability of the kidney to conserve water. Proposed mechanisms for this are interference with ADH, alterations of the counter-current system, and an increase in the renal sodium loss.[3,4]

Clinical Manifestations

The onset of clinical signs and symptoms may be gradual or, as with our patient, abrupt. Many of the symptoms are nonspecific, and this may contribute to delay in the diagnosis with resultant coma and renal failure. Common clinical manifestations of hypercalcemia include lethargy, epigastric discomfort, nausea, stupor, polydipsia, polyuria, and an increase in the heart rate. Symptoms may be mild or dramatic, depending in large part on the level of serum calcium and rate of change.

In cases of patients with breast carcinoma and known osseous metastases, any of these symptoms should alert the clinician to the possibility of hypercalcemia. Monitoring the serum calcium in this category of patients should be a part of the follow-up routine. If serum calciums are not readily available, then one could monitor urinary calcium by the Sulkowitch test as a screening aid. Although this test is not as sensitive as a serum calcium, it may aid in the early detection since hypercaluria frequently precedes development of hypercalcemia in these patients. Some patients with metastatic breast carcinoma will demonstrate a chronically elevated serum calcium, below the level necessary to produce stupor or coma. The elevated serum calcium may be persistent and difficult to control. Because of the functional changes caused by a prolonged hypercalcemia, one should follow these patients closely for the development of peptic ulcers, pancreatitis, a diabetes insipidus-like picture, and digitalis-induced arrhythmias.

Treatment

Hypercalcemia occurs in 10 to 25 per cent of patients with metastatic carcinoma of the breast at some time during their disease. This is especially true when osteolytic lesions are present by x-ray.[5] Early recognition and correction of the electrolyte imbalance is the goal. General measures to aid in lowering of the serum calcium have been investigated. Decreasing the dietary intake of calcium in these cases is of limited benefit, because the source of their elevated calcium is bone rather than diet. Adequate hydration is a very important part of the treatment of the problem both to prevent dehydration and to provide an adequate glomerular filtration rate and thereby aid in the excretion of the calcium. To augment adequate hydration there is now good evidence to suggest that delivering increased sodium to the proximal tubules promotes calcium excretion.[6] This could be accomplished initially by infusing isotonic sodium chloride; it is also known, however, that administering the sodium with a nonreasbsorbable anion such as sulfate further increases the calcium excretion. This form of therapy was chosen as the form of treatment for our patient. When using this mode of therapy, however, one must be alert to the probable complications of fluid overload, hypernatremia and hypokalemia. The problem of hypokalemia usually can be controlled by adding potassium chloride to the intravenous infusion. Addition of the newer diur-

eties such as Furosemide may help prevent the fluid overload and the hypernatremia. Furosemide may also have the additional benefit of increasing the excretion of calcium.[7]

As a general rule, the pre-menopausal woman should benefit from measures aimed at increasing the calcium excretion followed by castration. In the post-menopausal woman, or as in our patient with a surgical menopause, the effects of changes in hormone climate are not as predictable. In this group of patients, glucocorticoids offer the best chance of lowering the serum calcium and providing a long-term control.

Summary

A case of acute hypercalcemia crisis developing in a patient with metastatic breast carcinoma is reported. While many variables are involved in the production of hypercalcemia in this type of patient, it is the opinion of the authors that this was triggered by the administration of 5-Fluorouracil in adjunct with the hormonal manipulation with adrenalectomy. The patient had a normal serum calcium on admission, and there was no alteration in her hormonal therapy or her steroids. The patient has had an active, relatively pain-free life for 18 months since this case report. We feel that this is justification for aggressive management of this serious complication in patients who are undergoing palliation for their disease.

A list of references may be obtained by writing The Journal.

Prosthetic Devices

Artificial devices to replace practically every joint in the body are now either on the market or the drawing board. Moving away from the orthopedic arena, two significant clinical applications of other types of prosthetic devices were reported during 1973.

A new implantable prosthetic arteriovenous shunt for dialysis patients, one that appears to have distinct advantages over both the standard Quinton-Dillard-Scribner shunt and the Bresicia A-V fistula, has been developed and clinically tested at the University of Minnesota Hospitals.

Used to link the radial artery and cephalic vein, this U-shaped device, which is 5 cm long, can be implanted subcutaneously in the forearm or wrist. It can also be used in the thigh or groin.

A unique voice prosthesis developed by a plastic surgeon at New York Medical College can help laryngectomees achieve natural sounding speech. Fitted by an improved surgical procedure, the device — nonelectronic and reedless — permits more normal sounds without training and with normal inflection. The air bypass mechanism is lightweight, easy to clean, completely concealed and removed only while the user sleeps.

The Use Of Methylmethacrylate For Extensive Internal Bracing Of The Cervical Spine In Metastatic Disease

(A Case Report)

K. Douglas Bowers, Jr., M. D.; and Elliott L. Thrasher, M. D.

A 68-year-old male (D.S.) initially was admitted to the Neurologic Service of the West Virginia University Medical Center on July 17, 1969.

His primary complaint was the insidious onset of weakness in all four extremities which had begun approximately three months prior to admission and which was characterized by rather rapid progression. He also had noticed numbness and tingling in both upper extremities, mainly in an ulnar distribution bilaterally. There was no mention of pain. He had also noted progressive weight loss over a six-month period prior to his admission.

Physical examination revealed rather marked wasting and prominent fasciculations of the muscles of the hands, arms, shoulder girdle, trunk, hip girdle and legs. There was corresponding weakness of most all of these motor groups. He required assistance in standing and in walking. No involvement of facial muscles, tongue or pharyngeal muscles was noted. Deep tendon reflexes were depressed in the upper extremities, the abdominal reflexes were absent, and the knee jerks were equal at +2. The left ankle jerk was present but diminished and the right ankle jerk was absent. There was no evidence of clonus and the Babinski response was flexor bilaterally. Sensory perception was good throughout. Rectal examination revealed a diffusely enlarged prostate, which was firm but not hard and which was free of obvious nodules. He had full pain-free range of motion of the cervical spine.

Multiple laboratory procedures were obtained and were within normal limits with the exception of the serum acid phosphatase which was 4,600 K.A. units, prostatic fraction. EMG was suggestive of widespread neurogenic disorder of lower motor neuron variety. X-rays revealed diffuse osseous metastasis of the cervical, dorsal, and lumbar spine, and of the pelvis and ribs bilaterally.

On July 25, 1969, he underwent panendoscopy, cystoscopy and needle biopsy of the prostate under local anesthesia. The pathology report was adenocarcinoma of the prostate.

The Authors

- **K. Douglas Bowers, Jr., M. D., Clinical Associate Professor, Division of Orthopedic Surgery, West Virginia University School of Medicine, Morgantown; and Elliott L. Thrasher, M. D., formerly Chief Resident, Orthopedic Surgery, WVU, now a Research Fellow in Orthopedic Surgery at the Massachusetts General Hospital, Boston.**

On July 30, bilateral orchiectomy was performed. His postoperative course was uncomplicated and he was discharged on August 2.

He was followed as an outpatient in the Urology Clinic until August of 1972. During this period of time he was essentially pain free, had gained weight, and the muscle weakness of all four extremities had improved. Also during this period he was on no medications.

After a fall down a small hill in early November of 1972, he began to complain of neck pain. He was seen in the Orthopedic Clinic and cervical spine films revealed advanced degenerative change of the entire cervical spine with rather marked disc space narrowing at the C5-6 and C6-7 levels. There was no definite evidence of metastasis though as previously mentioned the original films on his admission in 1969 did apparently show evidence of cervical metastatic involvement. There was mild compression of C3 and C5.

He continued to be followed as an outpatient in the Urology Clinic, and on May 1, 1973, was still complaining of pain in his neck. An acid phosphatase on this date was 32 K.A. units prostatic fraction.

He was again seen in the Orthopedic Outpatient Clinic on May 14 because of the persistent complaint of neck pain. Radiograms on this occasion revealed pathologic fracture of C2

with rather marked instability of C1 on C2. The anterior fourth of the body of C2 along with an intact odontoid was rather markedly displaced anteriorly with C1. There was obvious metastatic involvement of most of the body of C2 with significant compression.

Physical examination on this occasion revealed marked weakness of the extensor digitorum communis, extensor hallucis longus, and the anterior tibial of his right lower extremity. No significant weakness in either upper extremity was noted. Deep tendon reflexes in the lower extremities were present but equally diminished and the Babinski response was flexor bilaterally.

He was placed in Crutchfield tong skull traction on a Stryker frame and admitted to the Orthopedic Service. Acid phosphatase on admission was 60 K.A., and he was begun on Diethylstilfestrol 1 mg. daily.

There was no evidence of pulmonary metastatic involvement and no evidence of involvement of the long bones of the lower extremities. Our plan at this time was to stabilize the cervical spine surgically and begin radiation therapy 10 to 12 days postoperatively.

On May 21, he was taken to surgery. Through a routine posterior midline incision extending from the inion proximally to the tip of C6 spinous process distally, the spinous processes and lamina of C1 through C6 were exposed. There was obvious instability of C1 on C2, and tumor involvement of the lamina of C2 on the left and the C2, C3, and C4 facets on the left was encountered.

With C1 reduced on C2, fixation was obtained using an 18 gauge wire looped around the posterior ring of C1 and running through and around the base of the spinous process of C2. No. 20 gauge wire was then passed under the lamina of C1 on both sides of the midline to be used to secure C1 to the internal splints. No. 20 gauge wire was then passed through the inferior facets of C2 through C5 being brought out posteriorly through the joint space, following the technique described by Robinson and Southwick.

Acrylic cement was rolled into two cylinders which were positioned longitudinally, one on either side of the midline extending over the lamina and facets from C1 to C5. These cylinders were gently compressed while still somewhat soft in order to conform to the contour of the posterior lamina and facets. The acrylic was continuously irrigated to prevent soft tissue damage from the heat as the cement hardened.

Figure 1. Postoperative lateral film showing acrylic splints wired into place with excellent alignment.

As soon as the acrylic was hardened the previously placed wires were then looped over the cylinders and tightened down firmly. The wound was then closed in a routine fashion without difficulty.

His postoperative course was completely uncomplicated. He was maintained on the Stryker frame in skull tong traction initially. The neurologic deficit noted preoperatively was unchanged postoperatively. Postoperative AP and lateral radiograms of the cervical spine revealed excellent alignment with excellent position of the acrylic splints and wires (see Figure 1).

On May 26, the Crutchfield tongs were removed. He was placed in a cervical fore-poster brace and on the same day began to sit and walk with assistance, both of which he tolerated well.

On June 4, he began high doses of palliative radiotherapy. He was to receive a depth dose of 4000 Rads. on super voltage therapy source with 1,335 Rads. as the weekly rate. On June 22, the radiotherapy was completed and he was discharged, ambulatory, with a walker and pain free. His surgical incision had healed well without difficulty.

On July 9, 1973, six weeks postoperatively, he

was pain free and independently ambulatory with the aid of his walker.

Discussion

This method of obtaining internal fixation seemed preferable to using cortical bone grafts in this case for several important reasons.

His life expectancy was relatively short and an eventual solid bony fusion was not an objective. Immediate stability which would allow early ambulation was most desirable.

He would not have tolerated prolonged postoperative skull tong traction well, nor immobilization in a heavy plaster Minerva jacket, which would have been indicated if autogenous cortical grafts had been used.

Because a donor site for autogenous cortical grafts was unnecessary, operative blood loss was minimized, operative time shortened, there was less postoperative pain and less operative and postoperative overall morbidity.

Postoperative radiation therapy could be instituted earlier and with greater ease to the patient. His total hospital stay was shortened.

At the present time we see no obvious disadvantage to this procedure. Postoperative radiation therapy apparently has no untoward effect. Investigators have previously pointed out that there is secondary irradiation from a metal fixation device or prosthesis which will lead to intensive ionization of immediately adjacent tissue. They have, however, found no ill effects clinically from this phenomenon, there being no significant changes in the tissues attributable to interaction between radiation and metal or cement.

A list of references may be obtained by writing The Journal.

Venereal Disease

Veneral disease continues to be a major health problem, second only to the common cold. Gonorrhea, the most frequently reported communicable disease, increased substantially during 1973 (fiscal year), with an incidence rate (reported cases) approximating nearly double that of five years ago.

Some 809,600 cases reported in 1973 represent a 12.7 per cent increase (91,280) over 1972 and the highest incidence ever reported since the Public Health Service established its record-keeping system in the early 1900s.

Although the increase is not as dramatic, more infectious syphilis cases have progressed through the entire infectious stage without being detected. During fiscal year 1973, early latent syphilis cases numbered 22,293 as compared to 20,354 in the preceding year, reflecting a 9.5 per cent increase.

Public health officials are optimistic about the impact of recently expanded gonorrhea casefinding programs for screening large numbers of females in high risk groups. During 1973 (FY), the male-female ratio of reported cases of gonorrhea was 1.7:1. Two years ago, the gonorrhea male-female ratio was 2.7:1.

The Result Of Management Of Seventy Consecutive Cases Of Malignant Melanoma From 1939 To 1972 In The Charleston General Hospital, Charleston, West Virginia

Han Seng Lee, M. D.

THE first accredited mention of melanoma was made by Hippocrates in the Fifth Century B.C. Lannec, in 1806, discussed "la melanose" and R. Carswell, in 1838,[28] first employed the term, "melanoma."

Pemberton, in 1858, advocated and performed a wide and deep dissection for melanoma, carrying the level of excision below the underlying fascia and removing implicated lymph nodes by groin dissection—a practice approved now, a century later[28]. Samson Handley[11], in 1907, recommended wide excision of the primary tumor associated with lymph-adenectomy. Pringle, in 1908, expanded the limit of the procedure to include the skin, subcutaneous tissue and fascia, the area of "lymphatic permeation" between primary tumor and regional node[30]. As one reads through the voluminous literature on melanoma, it becomes quite apparent that the basic treatment has not changed in more than 100 years, although through refinement of technique and the patients' earlier awareness of small lesions, the results have improved over the past 10 to 20 years.

Frequently Misdiagnosed

Because of rather protean manifestations and seemingly erratic behavior, this lesion frequently is misdiagnosed and mismanaged. Two cutaneous lesions, nevi and melanoma, inevitably are related in medical thinking, either because of the likelihood of evolution of the benign into its malignant counterpart or because of frequent difficulty in differentiating the two lesions. Pack et al. have noted the average white individual harbors at least 14.6 nevi of one type or another.

Allen and Spitz pointed out the significance of junctional activity of nevus as the likelihood of evolution into malignant melanoma. Their thesis, of course, is not that every junctional or compound nevus becomes a melanoma, but that with the exception of the few malignant blue nevi and rare giant nevi of children, every melanoma of the skin or mucosa arises from a junctional or compound nevus. In other words, the junctional nevus may: (1) lie dormant or (2) regress or develop into (3) an intradermal nevus, (4) the compound nevus, (5) the juvenile melanoma or (6) the melanocarcinoma[2].

The Author

- **Han Seng Lee, M. D., formerly Resident in Surgery at Charleston Area Medical Center (General Division); now serving as Resident in Plastic Surgery at the University of Kentucky Hospital, Lexington.**

The study of the malignant melanoma is important because (1) the majority of these "black cancers" originate from long-standing, pre-existing nevi, (2) the majority of melanomas would be prevented by excision of dangerous nevi, (3) the constant visibility of the tumor should enable an early diagnosis to be made and (4) although melanoma is the most accessible of all major cancers, it has the unwelcome distinction of lowest curability.[18]

Materials

The present report is based on experience with 70 consecutive cases of malignant melanoma (from now-melanomas) treated and followed at the Charleston General Hospital during the period from January 1939 to December 1972.

The term, "melanoma", is used to signify the malignant tumor only and does not include the junctional or compound nevus. All of the cases in this study had histological confirmation. The total number of cases is divided into two groups: the determinate group and the indeterminate. The determinate group is composed of the patients who had been followed longer than five years after definitive surgical procedure, and those who had died of melanoma within the five years. The indeterminate group is composed of those patients who were lost to follow-up within the five years after surgery, or who had died of other causes not related to melanoma within

the five-year period after surgery. This group also included those patients who refused treatment or palliative care and those with unavailable information.

Pack et al. and Lane et al. [18,12] suggest that in melanoma, a five-year postoperative period without evidence of tumor is a quite valid criterion for cure, although there are unusual cases in which the patient survived more than five years with the residual melanoma. Knutson and Spratt reported 95 per cent of recurrence within five years postoperatively from Ellis Fischel State Cancer Hospital and Cancer Research Center (EFSCH-CRC)[11].

All 70 patients in our series were white (Caucasian).

Between 1968 and 1972, there were 32 cases with 30 determinate cases, among which 25 were still living as of December 1972. Pack et al., in 1959, from New York Memorial Hospital, reported 37.7 per cent as a five-year survival rate[11].

Knutson, Hori and Spratt from EFSCH-CRC, in 1969, reported 36.7 per cent as a five-year survival rate and 29.5 per cent as a ten-year survival rate.

Literature by 17 authors regarding a five-year survival rate has been reviewed and revealed the lowest rate to be 9.7 per cent by R. W. Raven (1950); highest rate by Rockwell at 59.2 per cent; the average of these rates was 33.9 per cent[11].

Table 1. End Results in the Treatment of Melanoma

Period	Total Cases	Determinate Cases	Living as of December 1972	Years Survived	Five-Year Cure	%
1939 - 1967	38	32	11	1Y–11 4Y–1 2Y– 3 5Y–1 3Y– 4	12	37.5
1968 - 1972	32	30	25	1Y–4 4Y–0 2Y–0 5Y–0 3Y–1		

There were 38 cases between 1939 and 1967 with 32 determinate cases, among which 12 cases survived longer than five years (five-year survival rate 37.5 per cent). Eleven patients were living as of December 1972. Among those who died within five years after surgery, 11 patients survived one year, three patients survived two years, four patients three years, one patient four years and one patient close to five years.

Table 2 shows the age and sex distribution. The average age of all cases was 51.2 years. Thirty cases were male, and 40 were female. Many observers report that there is no real difference in incidence of melanoma between the two sexes. Pack et al. show a ratio of one to one between male and female in 744 cases, in 1945. Spratt et al.—one to one in 230 cases, in 1969. In our series there were more female cases.

Table 2. Age and Sex Distribution

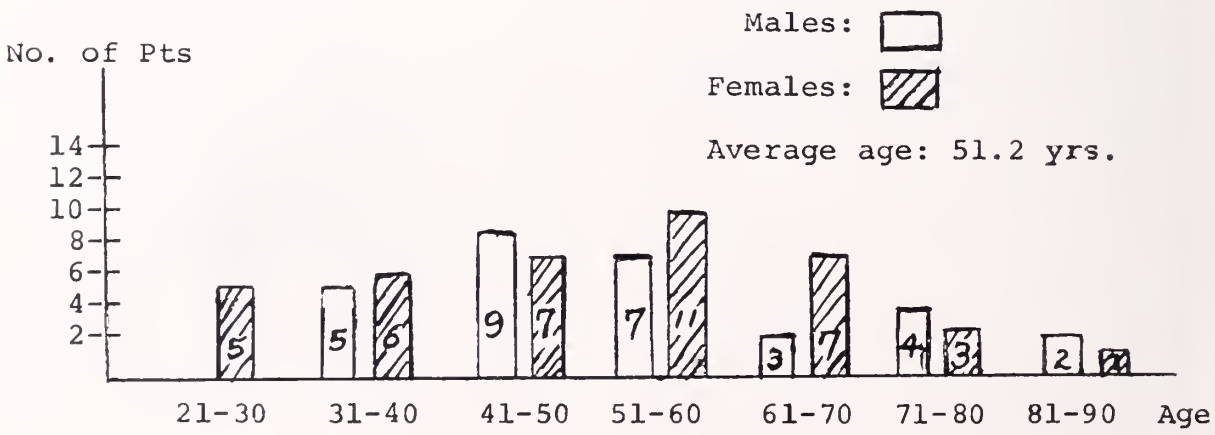

Table 3. Clinical Manifestations With 37 Cases and Available Information

Increase in pigmentation	18 = 48.9%
Increase in size	17 = 45.9%
Ulceration	14 = 37.8%
Hemorrhage	13 = 35.1%
Pain (local)	7 = 18.9%
Other symptoms (Itching, burning, et cetera.)	5 = 13.5%

Among 37 cases with information recorded, 18 (48.9 per cent) had an increase in pigmentation of pre-existing moles. Seventeen cases (45.9 per cent) had an increase in size. Fourteen cases (37.8 per cent) had ulceration. Thirteen cases (35.1 per cent) had hemorrhage. Seven cases (18.9 per cent) had pain, and five cases (13.5 per cent) had other symptoms such as itching and burning of these moles.

Ackerman, in 1948, suggested that approximately 50 per cent of melanomas arise from pre-existing nevi. In practically all instances, however, these nevi were junctional in nature, as previously mentioned. For this reason and others, excisional biopsy for any nevus which changes appearance in any way (as described in Table III) is recommended. As Potter[21] stressed, excisional biopsy is recommended for the following: (1) any nevus on the sole, palm or genitalia, on the assumption that there is proportionately high incidence of junctional nevi in these areas, (2) all blue nevi, which are difficult to differentiate from early melanoma and (3) any nevus which is subjected to chronic trauma or irritation.

Table 4. Duration of Lesion With Information Recorded: 37 Cases

Less than one year	19 = 51.3%
Two to five years	8 = 21.6%
Six to ten years	5 = 13.5%
Longer than ten years	5 = 13.5%

In 37 cases information about the duration of existence of moles was available. Nineteen cases (51.3 per cent) had a history of less than one year; eight cases (21.6 per cent) two to five years; five cases (13.5 per cent) six to ten years and five cases (13.5 per cent) had longer than ten years' duration of existence of the mole prior to surgical procedures.

As one can see, the majority of patients had a history shorter than five years, more than half of the cases within one year. This is compatible with the suggestion by H. Williams[31] that the more recent the onset of the mole, the more its potentiality for becoming malignant.

Table 5 shows survival rates according to sex. Of the 70 cases, 30 were male and 40 were female. From 1939 to 1967, determinate male cases were 11 of which five cases survived longer than five years (45.6 per cent). There were 21 determinate female cases with seven cases surviving more than five years (33.3 per cent). Between 1968 and 1972, there were 15 determinate male cases with only 10 cases living as of December 1972. Spratt et al. reported 53.5 per cent for the male and 46.5 per cent for the female as the five-year survival rate in 250 cases in 1971. Chase and Schwartz[3] stated that females were affected more than twice as frequently as males, but the five-year survival rates were better for females.

Most literature describes a somewhat higher survival rate in females, which is in contrast to our series. Pack et al. were strongly doubtful that there was a real sex difference in prognosis of melanoma, and pointed out the fact that women are more "cancer conscious" and tend to see their doctors earlier because of a "mole" which is changing in appearance.

Table 6 shows the incidence and survival rate according to the location of the melanoma. The

Table 5. Survival Rate According to Sex

GT—Grand total number of cases.
IC—Indeterminate cases.
DC—Determinate cases.
5Y SV—Five-year survivals.
%—Percentage.
LV DEC. '72—Living as of December 1972.

Valuables	GT	1939-1967					1968-1972			
		T NO	IC	DC	5YSV	%	T NO	IC	DC	LV DEC '72
Males	30	13	2	11	5	45.6	17	2	15	10
Females	40	25	4	21	7	33.3	15	0	15	15
Totals	70	38	6	32	12	37.5	32	2	30	25

Table 6. Survival Rate According to Location of Melanoma

H & N—Head and neck.
UP EX—Upper extremity.
LO EX—Lower extremity.
AR & G—Anorectal and genital area.
PSU—Primary site unknown.

(Please refer to the symbols used in Table 5 for additional explanation.)

Valuables	GT	1939-1967					1968-1972			
		T NO	IC	DC	5YSV	%	T NO	IC	DC	LV DEC '72
H & N	19	8	2	6	3	50	11	2	9	8
UP EX	9	4	0	4	2	50	5	0	5	5
LO EX	14	7	4	3	1		7	0	7	6
TRUNK	22	15	0	15	4	26.6	7	0	7	6
AR & G	4	3	0	3	1	33	1	0	1	0
PSU	2	1	0	1	1		1	0	1	0
Total	70	38	6	32	12	37.5	32	2	30	25

highest incidence was on the trunk, with 22. Between 1939 and 1967, there were 15 determinate cases of melanoma of the trunk and of these, only four cases survived longer than five years (26.6 per cent). The survival rate of melanoma of the trunk is slightly lower than the overall average rate, which can be explained by the fact that the lymphatic drainage of the trunk is more unpredictable than that of any other part of the body[9]. Melanoma of the head and neck showed slightly higher survival rate than the overall average rate of our cases (three cases survived out of six determinate cases between 1939 and 1967). The data from several literatures show that the melanomas arising from the head and neck have a better prognosis than those arising from the trunk and limbs. Veronesei (National Cancer Institute and WHO International reference center for melanoma in Milan, Italy) suggested that the better prognosis of melanomas originating on the head and neck is related to the fact that they less frequently give rise to regional lymph node metastases[29]. No survival rate could be expected from the patient in whose case the primary site was not identified, because the primary site could not be excised.

One patient, however, (November 1966) showed a lump in the left groin, which was biopsied and reported as melanoblastoma (T-2702-66, CGH). Eighteen days after this biopsy, a radical ilioinguinal dissection was performed, which did not show any residual tumor. This patient was seen on February 23, 1971 with no evidence of melanoma. Thirty-seven of 992 cases at Memorial Hospital in New York had unknown primary origin of melanoma, 13 of which had an incurable condition (their Stage III). All of these died within five years. Of 24 cases, (Stage II), 10 were cancer-free at five years after radical surgery[15]. This observation strongly supports the concept of treating cancer where it is and is compatible with one of our cases. One case in our series (1961) had an anorectal polyp which was biopsied and followed by abdominoperineal resection. This patient did not show any evidence of melanoma until June 1967, but died of a myocardial infarction in December 1968.

Table 7. Survival Rate According to the Size of the Melanoma

(Please refer to the symbols used in Table 5 for additional explanation. SND—Size not described on record.)

Valuables	GT	1939-1967					1968-1972			
		T NO	IC	DC	5YSV	%	T NO	IC	DC	LV DEC '72
≤ 1 cm.	23	11	2	9	7	77.8	12	0	12	10
1-2 cm.	14	8	1	7	3	42.8	6	1	5	5
≥ 2 cm.	18	11	1	10	1	10.0	7	1	6	5
SND	15	8	2	6	1	16.6	7	0	7	5
Total	70	38	6	32	12	37.5	32	2	30	25

Table 7 shows the survival rate according to the size of melanoma. From 1939 to 1967, 11 cases had melanomas less than one centimeter in its greatest dimension. Seven cases out of nine determinate cases survived longer than five years. In the same period, 11 cases had melanoma over two centimeters, one case was lost to follow-up. Among 10 determinate cases, only one case survived longer than five years. Lane et al. reported that melanoma less than two centimeters—61 per cent, over two centimeters—16 per cent as the five-year survival[12]. Lehman et al. reported less than one centimeter—69 per cent, one to two centimeters—35 per cent and over two centimeters—22 percent as the five-year survival rate. It seems to be apparent that the smaller lesions have a much better prognosis (Lund and Ihnen)[14] as in our series.

and 56 per cent five-year survivals when nodes were negative for metastasis. Although the size of our series is small, it seems to be apparent that if regional lymph nodes are positive for metastasis, the survival rate will be less than half of those with nodes negative for metastasis. Many patients with lymph nodes negative for metastasis are not able to get a definitive cure even after nodal dissection, in which case it seems logical to think that metastasis has occurred by the blood stream before definitive surgical procedure, since it has been suggested that 25 per cent of melanoma spreads through the blood stream[2].

Table 9 shows the survival rate according to various surgical procedures, which are grouped into four. The first group had an excisional margin from the margin of melanoma less than

Table 8. Survival Rate According to Lymphnode Involvement (Histological)

RN—Radical Neck
AD—Axilliary Dissection
GD—Groin Dissection
APR—Abdominoperineal Resection
PD—Popliteal Dissection

(Please refer to the symbols used in Table 5 for additional explanation.)

Valuables	GT	1939-1967					1968-1972			
		T NO	IC	DC	5YSV	%	T NO	IC	DC	LV DEC '72
RN LN (−)	3	2	0	2	0		1	0	1	1
RN LN (+)	1						1	0	1	1
AD LN (−)	7	2	0	2	1		5	0	5	5
AD LN (+)	5	3	0	3	0		2	0	2	1
GD LN (−)	5	4	1	3	2		1	0	1	1
GD LN (+)										
APR LN (−)	3	1	0	1	1		2	0	2	1
APR LN (+)	2	2	0	2	0					
PD LN (−)	1	1	0	1	0					
Total	27	15	1	14	4		12	0	12	10

Table 8 shows the survival rate of 27 cases who had wide local excision and lymph node dissection. Fifteen cases underwent radical lymph node dissection from 1939 to 1967. Among these cases, one was lost to follow-up and four survived more than five years. Their specimens of radical dissection did not show any evidence of metastasis of melanoma histologically. Pack et al., in 1952, reported 14.1 per cent of five-year survivals when regional lymph nodes were involved, but 40.5 per cent when nodes were negative for involvement. Spratt et al. (EFSCH-CRC) in December 1971 reported 24 per cent five-year survivals when nodes were positive,

three centimeters. The second group had a wide excision with more than three centimeters of excisional margin. Group three had a wide local excision and lymph node dissection in continuity. The last group had wide local excision and lymph node dissection with discontinuity. Although the size of the sample is small, one can easily see the low survival rates in the groups who had wide local excision and lymph node dissection with incontinuity. To elucidate this unsuspected sequence, all six determinate cases of group three were reviewed again, and the possible factors of low survival rate were illustrated by referring to the literature. Among

Table 9. Survival Rate According to Different Surgical Procedure

WLE—Wide Local Excision.
LND—Lymph node Dissection.

(Please refer to the symbols used in Table 5 for additional explanation.)

Valuables	GT	1939-1967					1968-1972			
		T NO	IC	DC	5YSV	%	T NO	IC	DC	LV DEC '72
Local Exc. Margin $\leq$ 3 cm.	12	9	2	7	2	28.6	3	1	2	0
WLE—Margin $\geq$ 3 cm.	32	15	3	12	6	50.	17	1	16	16
WLE & LND Incontin.	11	7	1	6	1	16.6	4	0	4	3
WLE & LND Discon.	15	7	0	7	3	42.8	8	0	8	6
Total	70	38	6	32	12	37.5	32	2	30	25

six cases who had wide local excision and lymph node dissection incontinuity between 1939 and 1967, the first case had an anorectal polyp, survived seven years after the abdominoperineal resection and finally died of a myocardial infarction. The second case had melanoma at the anorectal junction and had undergone abdominoperineal resection, with lymph nodes positive for metastasis and died within a year after surgery.

Pack et al. had 10 cases of melanoma at the anorectal junction between 1917 and 1945. All of these patients died within five years. It is generally agreed that melanoma of the mucous membrane of urogenital and anorectal areas and of the head and neck have an almost uniformly fatal prognosis[2].

The third case had a melanoma of the left scapular area, which was widely excised and grafted (10 x 12 cm.). Three years later, this case showed up with a mass in the left axilla, for which left axillary dissection was performed. Obviously, this third case had an unfavorable situation, because axillary dissection was performed for clinically positive metastasis, also histologically positive. It seems to be apparent that more observers recommend prophylactic axillary dissection rather than therapeutic dissection for enlarged glands.

The fourth case had a melanoma eight mm. in diameter in the right side of the neck with hemorrhage, ulceration and darkening, of three months' duration. Radical neck dissection was performed five weeks after the primary excisional biopsy. Tompkins, in 1953, stated that a patient with ulcerated melanoma had a 60 per cent chance of dying of melanoma within three years, whereas only a five per cent chance if the lesion did not ulcerate. Perzik also reported that the five-year survival rate was 45.9 per cent with ulcerated lesions, and 75.4 per cent without ulceration in their 162 cases[20].

The fifth case had a lesion at the rectovaginal septum over two centimeters in diameter. This case had a polyp removed from the rectum (April 21, 1966) in Baltimore, Maryland, which was reported as a benign lesion. On November 1, 1966, a biopsy was performed from the rectovaginal septum in our hospital, and this was reported as melanoma. Following this a sigmoidoproctovaginectomy with colostomy was performed on November 3, 1966. The first slide from Baltimore, Maryland, was reviewed by our pathologist and reported as identical to the slide made from the lesion in the rectovaginal septum (November 1, 1966). One will also expect a very poor prognosis in the fifth case.

The sixth case had two lesions at the left upper back, which were biopsied and followed by left axillary dissection four weeks later. The patient showed axillary lymph nodes positive for metastasis. This patient died within one year following surgery.

All of the foregoing cases had apparent factors pointing to an unfavorable prognosis.

In some instances of melanoma, even without apparent fallacy in management, patients died earlier than expected. Whenever melanoma spreads by hematogenous routes, even though the operation is ably executed, failure will result, as many of our patients have shown.

Between 1968 and 1972, only three out of 32 cases had simple local excisions with less than three centimeters of excisional margin and two of them had expired by December 1972.

As one can see in Table 9, more patients seem to be undergoing radical procedures recently. This probably is due to the fact that surgeons and patients nowadays are more aware of the nature of melanoma.

Table 10. Survival Rate According to the Various Types of Closure

PC—Primary Closure
SG—Skin Graft
RF—Rotation Flap
Total WLE—Total wide excision with or without lymph node dissection.

(Please refer to Table 5 for explanation of other symbols used in this table.)

Valuables	GT	1939-1967					1968-1972			
		T NO	IC	DC	5YSV	%	T NO	IC	DC	LV DEC '72
PC	32	22	2	20	7	28.6	10	0	10	10
SG	24	8	2	6	3	50.	16	1	15	14
RF	2	1	0	1	0	0	1	0	1	1
Total WLE	58	31	4	27	10	37.0	27	1	26	25

Table 10 shows the survival rate according to the various types of closures in 58 patients with information available. Between 1939 and 1967, 31 cases had a wide local excision, among which 22 cases had primary closures and eight cases had skin grafts.

The survival rate of patients who had skin grafts for closure was somewhat better (50 per cent) than that of those who had primary closure (28.6 per cent). Although the size of this sample is not large enough to make valid conclusions, one can find in Table 10 the fact that a larger number of cases are getting skin grafts recently for closure than was true in the past. When melanoma is found, three dimensional excision should be performed widely and ruthlessly, sacrificing the skin in all directions (over five centimeters — McNeer, DasGupta and G. Pack)[19].

nineteen determinate cases surviving longer than five years (42.1 per cent).

Group II had definitive surgical procedures later than one month from excisional biopsy. From 1939 to 1967, there were eight cases in Group II, with seven determinate cases, among which one case survived longer than five years (14.3 per cent).

Even though the size of the sample is small, the difference in survival rates beween Group I and II is distinct. Between 1968 and 1972, there has been more tendency to undertake immediate definitive surgical procedures. Pack et al., in 1952, reported, in their series of 1190 cases, that the five-year cures decreased from 39.9 per cent to 17 per cent when definitive surgery was delayed more than one month. The importance of avoiding delay in definitive procedures cannot be over-emphasized.

Table 11. Survival Rates According to Delay in Definitive Surgical Procedure—In 56 Cases with Information Recorded

I—Immediate: No previous or local excision within one month of definitive surgery.
II—Delayed: Local excision more than one month prior to definitive surgery.

(Please refer to the symbols used in Table 5 for additional explanation.)

Valuables	GT	1939-1967					1968-1972			
		T NO	IC	DC	5YSV	%	T NO	IC	DC	LV DEC '72
I	45	22	3	19	8	42.1	23	1	23	23
II	11	8	1	7	1	14.3	3	0	3	1
Total	56	30	4	26	9	33.3	26	1	26	24

Group I had immediate definitive surgical procedures, which were performed simultaneously with excisional biopsy or within one month from the excisional biopsy. There were 22 cases who had immediate definitive procedures between 1939 and 1967 with eight out of

Review of the Literature Regarding Treatment of Melanoma

Surgical Treatment. — It is commonly accepted that inadequate surgery of primary site of melanoma is an adverse factor in prognosis and may produce exploration of disease[29].

As with most forms of malignant lesions, there is considerable controversy as to the best treatment of melanoma. Almost all surgical observers would agree that when diagnosis of melanoma has been confirmed histologically by biopsy or initial excision, a prompt wide local excision should be performed. This usually involves the skin, subcutaneous tissue and underlying fascia, which is based on the capacity of the melanoma to disseminate into the subepithelial lymphatics surrounding the primary tumor to establish satellite deposits[21].

The recommendation of Sampson Handley, in 1907, for a minimal excision of five centimeters around the melanoma is good advice. The international group for clinical study of melanoma recommends a minimum of three centimeters in all directions[6]. Most of the literature recommends wide local excision and lymph node dissection incontinuity (monobloc procedure) if the melanoma is situated in relatively close proximity to regional lymph nodes into which one might reasonably expect lymph node borne metastasis to be deposited.

Stehlin suggested that two-thirds of the elliptical excision be in the direction of the spread of the original lesion. The critical decisions concern the performance of an immediate dissection of the lymph nodes incontinuity or as a discontinuous procedure; performance of a delayed lymph node dissection; the value of prophylactic or therapeutic node dissection.

Neck Dissection. — Neck dissection incontinuity is a reasonable procedure for the melanoma of the head and neck, except for a large centrally located lesion of the scalp and forehead, for which cases Veronesei et al. suggest radiotherapy[29]. There is no demonstrable advantage of prophylactic over therapeutic dissection if the latter is performed as soon as the significant lymph nodes are detected[17].

Axillary Dissection.—As briefly mentioned previously, it is reasonable to perform an axillary dissection incontinuity with excision of the primary lesion within five inches of the outer borders of the axilla. Prophylactic axillary dissection is recommended since this is seldom plagued with such complications as necrosis of the skin margin, edema of the arm or so-called satellitosis metastasis or stasis metastasis[17], or both.

Epitrochlear Lymphnode Dissection — This is unnecessary.

Groin Dissection. — These are frequently complicated by necrosis of the skin margin, delayed healing, thrombophlebitis, prolonged drainage of the lymphatic fluid from the wound and infection. About 20 per cent of all groin dissections were complicated by satellitosis metastasis or stasis metastasis. Because of this fact, Moore and Gerner of Roswell Park Memorial Hospital, Buffalo, New York, suggested that groin dissection should not be standard procedure, and only superficial groin dissection should be performed in those cases with clinically insignificant lymph node enlargement. Also, that radical groin dissection in the presence of grossly involved lymph nodes over four centimeters in diameter or involved lymph nodes which have fused is unreasonable[17].

Irving M. Ariel suggested that resection of the lymph nodes in the groin, even in the absence of clinically demonstrable metastasis, is indicated since as much as 40 per cent of the patients with primary melanoma will develop metastasis to the regional lymph nodes.

Pack and Reker have demonstrated that when an elective groin dissection is performed, that is, no clinical evidence of metastasis to the lymph nodes, 29 per cent of the patients presented had microscopically identifiable melanoma in the inguinal lymph nodes, although surgeons found no gross evidence of involvement at operation.

If the primary lesion is in the vicinity of the groin, monobloc resection of the malignant lesion, intervening lymph vessels and lymph nodes of the groin is reasonable. If the primary lesion is distant from the groin, many surgeons perform discontinuous operation, which ignores the lymphatic vessels, intervening between the resected tissues. For this reason, Ariel recommended the extended groin dissection, dissecting the entire anteromedial aspect of the thigh down to the level of the popliteal space, which permits the removal of 50 per cent of the lymphatics of the entire thigh, since most of the lymphatics drain through the anteromedial aspect.[4]

Hugh Bailey and David Gray of the Charleston General Hospital in Charleston, West Virginia, in 1957,[10] described a new technique for radical ilioinguinal lymph node dissection. They suggested that division of the inguinal ligament at the anterior superior spine during the procedure did not result in abdominal weakness or herniation. They also emphasized that bulky, compressive dressings and bed rest decreased the fluid accumulation in the wound, which was a paramount factor in the prevention of skin sloughing.

Popliteal Dissection. — McNeer and T. D. Gupta, in 1965, pointed out that metastasis in lymph nodes of the ipsilateral groin is invariably

the first lymph node involvement of melanoma arising from any given site of the lower extremity; that metastasis to the popliteal lymph nodes is so rare that the possibility of its occurrence should not enter into the concept of management of melanoma of the lower extremities[15, 31].

Amputation.—This is a harsh form of treatment for any disease; when, however, it offers an increased opportunity for survival or cure for the patient with a malignancy, it becomes a more acceptable form of treatment. Amputation for melanomas of the lower extremities is performed usually when the lesions are considered incurable by any other means, especially if the location of the melanoma in the lower extremity precludes the *en bloc* or the incontinuity dissection of the primary or recurrent disease with clinically positive lymph nodes[5].

McNeer and Booker of Memorial Hospital, New York, reported a total cure rate of five years for the patient with recurrent and local or regional metastatic melanoma treated by major amputation as 18 out of 54 cases (33.3 per cent) in 1963[5]. Most surgeons after a few frustrating failures will reach the conclusion that amputation for melanoma is futile. From the many clinical studies of melanoma, there evolved little or no encouragement for the use of amputation in its treatment.

Recently, Ariel at Memorial Hospital, New York, has applied the endolymphatic administration of radioactive isotopes using I-131 Ethiodol in addition to surgical procedures. This showed encouraging results, but the exact role of the procedure still is to be determined by continuous clinical trial[3].

Regional Perfusion.—Results of systemic chemotherapy with a variety of agents (Cytoxan Leukeran, Alkeran) for melanoma had been rather disappointing[26]. One of the main factors causing unsatisfactory results in chemotherapy of any cancer is that the administration of doses large enough to significantly affect the tumor produces serious effects on the bone marrow and gastrointestinal tract. To overcome this problem in chemotherapy, Creech and Krementz, in 1958, applied regional perfusion with phenylalanine mustard (PAM), utilizing an extracorporeal circuit (heart-lung bypass) for the melanoma in the extremities[8].

Ever since then, there have been many reports about this procedure, with various results (D. Rochlin, W. Shingleton, J. Stehlin, Jr., L. Clark) [22,24,27]. It seems to be agreed that the regional perfusion may be a valuable adjunct to surgical treatment of melanomas arising in the epitrochlear region and below the upper extremity and all melanomas arising on the lower extremity, especially if the lesions do not lie adjunct to the regional lymph nodes [8,22,24,25,27]. Regional perfusion seems to reduce the incidence of local recurrence within the extremities and the necessity for radical amputation[27]. Although, this could be a palliative measure for advanced lesions, this carries definite hazards.

Summary

(1.) A brief history of melanoma and the importance of proper management of nevi (moles) are presented.

(2.) Seventy cases of melanoma have been reviewed. There were 38 cases between 1939 and 1967, and 32 cases between 1968 and 1972. The five-year survival rate of the cases from 1939 to 1967 was 37.5 per cent, which is similar to other reports from larger centers (Pack et al. 37.7 per cent in 1959 from Memorial Hospital in New York; Spratt et al. 36.7 per cent in 1959 from EFSCH-CRC; the average of 17 observers' reports was 33.9 per cent).

(3.) There were 30 males and 40 females. The average age was 51.2 years.

(4.) The importance of excisional biopsy of "moles" changing their appearance is emphasized.

(5.) The shorter the duration of moles, the greater potentiality of their being malignant is suggested.

(6.) The five-year survival rate of the male from 1939 to 1967 was 45.6 per cent; the female rate was 33.3 per cent; there has been doubt, however, as to whether any real difference in the survival rate between the sexes exists.

(7.) The survival rate of melanoma of the head and neck was higher; the rate of melanoma of the trunk was lower than the overall survival rate.

(8.) The smaller lesions of melanoma showed definitely better survival rates than the larger lesions (less than one centimeter lesion—77.8 per cent five-year survival rate; more than two centimeters—10.0 per cent five-year survival rate (Table 7).

(9.) Four patients out of 13 determinate cases, who had undergone radical lymph node dissection, survived longer than five years. These four patients showed negative metastasis in their lymph nodes, histologically and clinically. All of the patients who were positive for metastasis in the lymph nodes, died within five years following surgery (Table 8).

(10.) The survival rate of the cases who had undergone wide local excision and lymph node dissection, either incontinuity or discontinuity, which has been the most reasonable procedure for the management of melanoma, was unexpectedly low. The factors contributing to this low survival rate and some probable fallacies in the management of these patients have been reviewed by referring literature for the purpose of improvement in our patient care in the future[9].

(11) The survival rates of the cases who had skin grafts for closure were somewhat higher than the rates of those who had primary closure. Nowadays there has been more tendency to undertake skin graft or rotation flap for closure than in the past.

(12.) The delay in definitive surgery after initial diagnosis of melanoma showed a definitely lower survival rate. The importance of avoiding delay in definitive procedures is emphasized.

(13.) Literature regarding the treatment of melanoma by surgical procedures and regional perfusion is reviewed and summarized.

A list of references may be obtained by writing The Journal.

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Special Article

The Blood Pressure of 688 Sophomore Medical Students

Edward J. Van Liere, M. D., Ph. D.; and J. Clifford Stickney, Ph. D.

During the past two or three years there has been a wide interest in screening people for hypertension. A federal task force (Med. News, Feb. 21, 1973) headed by Mitchell Perry, Jr., M.D., is presently undertaking large scale screening programs for hypertension in the United States. Also, the principal community program for the American Heart Association for 1973 was to foster wide screening programs.

The West Virginia Affiliate of the American Heart Association is also participating in this program. Doubtless a vast amount of data will be accumulated. The matter of screening for hypertension is a most important one, for it has been estimated that between 10 and 15 per cent of people have some form of hypertension. Another estimate is that 20,000,000 to 25,000,000 people in the United States are hypertensives. Prevalence rates are about twice as high for black as for whites.

Since there is presently such a marked interest in blood pressure levels it was deemed worthwhile to publish blood pressure determinations obtained on 688 sophomore medical students (629 men and 59 women) who were enrolled in the West Virginia University School of Medicine between the years 1944 to 1963 inclusive.

The determinations were made on a fairly homogeneous group. The students were all about the same age, all lived approximately in the same environment (the vast majority lived in West Virginia), all were engaged in the same occupation, and the blood pressures were obtained in the same location, namely under relatively relaxed conditions as a routine laboratory procedure. The determinations were all made approximately the same time of day, between 1:30 P.M. and 4:30 P.M. Reporting this project seemed in order since there is evidence that young people with an elevation of blood pressure may later develop some form of hypertension.

Procedure

The blood pressure of the students was measured by the auscultatory method, first described by the Russian physician, Nicolai Korotkoff, born in 1874. Some of the determinations were made with a mercury sphygomanometer and some with the common Tycos aneroid variety. The latter were calibrated from time to time to insure accuracy. The armlet was placed on the upper arm so that the pressure in the brachial artery could be measured. The systolic pressure was ascertained in the usual manner; the diastolic pressure at the beginning of phase IV of the Korotkoff sounds.

Determinations were made in the sitting, standing and lying positions. In practically all instances several determinations were made on each person. Although the blood pressure was taken by the student, the determinations were made under the supervision of a laboratory instructor, and in some instances the latter checked the results. The blood pressures listed in this report were those taken in the sitting position.

Results

The mean blood pressure was 119/79 mm. Hg. (men 120/80 mm. Hg.; women 113/75 mm. Hg.). Twenty-seven (3.9 per cent) students had a diastolic pressure of 90 mm. Hg., and 25 (3.63 per cent) had a diastolic pressure of more than 90 mm. Hg. The highest diastolic pressure reported was 110 mm. Hg. Six students had a systolic blood pressure of over 140 mm. Hg., the accepted upper limit of normal; the highest systolic pressure recorded was 150 mm. Hg.

Discussion

The blood pressures were taken by medical students. Although all of them had received technical training in biology, chemistry and physics laboratories it was their first experience in taking blood pressure on human beings. In many instances the instructor checked their findings, and as a rule more than one determination was made in any one position.

There is a diversion of opinion on what con-

The Authors

- **Edward J. Van Liere, M. D., Ph.D., Emeritus Dean and Emeritus Professor of Physiology and Biophysics; and J. Clifford Stickney, Ph.D., Professor of Physiology and Biophysics, West Virginia University School of Medicine, Morgantown.**

stitutes a normal blood pressure. The American Heart Association holds that normally the systolic pressure should not exceed 140 mm. Hg. and the diastolic not exceed 90 mm. Hg. Dr. Carl Wiggers, the late eminent cardiovascular physiologist, held that the figures just given may be regarded as ceilings for blood pressure readings under basal conditions at all ages. On the other hand, the federal task force mentioned earlier suggests that systolic pressures of 160 mm. Hg. and diastolic pressures of 95 mm. Hg. are not abnormal in people who are 45 years old or less. This appears to be a liberal interpretation.

There are some who believe that normally blood pressure rises with age. Those who govern the policy of the task force evidently believe this, because it allows an additional 10 mm. Hg. for each level, that is, both systolic and diastolic over the age of 45 years. This would permit a systolic pressure of 170 mm. Hg. and a diastolic of 105 mm. Hg. These generous figures are not accepted as normal by all internists. There are some clinicians who believe that so long as the diastolic pressure does not rise above 100 mm. Hg. the patient should not be diagnosed a hypertensive. Some clinicians, furthermore, are not particularly interested in an elevation of the systolic pressure.

Be all that as it may, it probably is well to take a conservative view of the entire matter and accept the criterion of the American Heart Association, that is, under basal conditions the systolic pressure should not rise above 140 mm. Hg. and the diastolic above 90 mm. Hg.

In evaluating the blood pressure determinations of the students it is noteworthy that 27 (3.9 per cent) had a diastolic pressure of 90 mm. Hg.; 25 (3.63 per cent) had a diastolic pressure exceeding this. The question arises whether students whose average is about 23 years should have a diastolic pressure of 90 mm. Hg. This figure according to some students of the subject is the upper limit of the acceptable normal—at least for young people. Would such students in later life be more apt to develop hypertension in some form? It is possible that they might do so, although this has not been proved. Those students who had a diastolic pressure of more than 90 mm. Hg. probably would be even more apt to develop hypertension in later life. It would be well for these individuals to have their blood pressures determined periodically to ascertain whether there was a tendency for the diastolic pressure to rise.

Only six students had a systolic pressure above 140 mm. Hg., the generally accepted upper level of normal. The highest systolic pressure observed was 150 mm. Hg. (this student had a diastolic pressure of 110 mm. Hg.). It is gratifying that such few students showed an elevation of systolic pressure. It is generally believed, of course, that an elevation of the diastolic pressure is far more important than an elevation of the systolic pressure. It is to be remembered that the diastolic pressure is the lowest pressure to which the arteries are constantly subjected. This is an important matter when the time relations of the cardiac cycle are considered.

In 1967 Murphy (Murphy, T., et al, Johns Hopkins Medical Journal, 120:1, 1967) published blood pressure determinations made on 1,091 white male students registered in Johns Hopkins University between the years 1948 and 1964. Their average age was 23.1 years. The mean systolic pressure measured in the recumbent position was 122.2 mm. Hg. and the diastolic 69.5 mm. Hg. The systolic pressure did not vary much from the figure we are presenting (120 mm. Hg.). The mean diastolic pressure reported by Murphy et al, however, (69.5 mm. Hg.) is considerably less than our figures (80 mm. Hg.). Presumably the diastolic pressures reported by Murphy et al were read at the same point as those we are reporting, namely at the point of muffling.

The lower reading they reported may be due to one of several factors. Our observations were made on patients in the sitting position, whereas they instructed their subjects to lie down. Furthermore, the place the pressures were taken varied somewhat; those we are reporting were taken in the student laboratory whereas they used a quiet room. Finally, the blood pressures we are reporting were determined by medical students, whereas those reported by Murphy et al were determined by experienced personnel.

Unfortunately, hypertension in its early stages, produces no symptoms and patients are unaware of their elevated blood pressure. It, too, is unfortunate that there are many people who do not realize that essential hypertension can be readily controlled. This was not true in the past. Today, however, both systolic and diastolic pressures can be brought down to acceptable levels by daily administration of a diuretic and antihypertensive preparations. It has been definitely shown that if hypertension is adequately controlled, dangerous sequelae, such as cardiomegaly, strokes or coronary episodes can be greatly lessened. In short, there has been a tremendous advance in the management of essential hypertension. The public should be fully informed of this fact.

Summary

Blood pressure determinations were made on

688 sophomore medical students, 629 males and 59 females, who were enrolled in the West Virginia University School of Medicine between the years 1944 to 1963, inclusive. It was a fairly homogeneous group. The average systolic blood pressure for the entire group was 119 mm. Hg. and the average diastolic pressure 79 mm. Hg. The respective figures for the males were 120 and 80 and for the females 117 and 75.

Only six students had a systolic blood pressure of more than 140 mm. Hg. The highest systolic pressure observed was 150 mm. Hg. Twenty-seven students had a diastolic pressure more than 90 mm. Hg. The highest diastolic pressure observed was 100 mm. Hg.

It was suggested that those students who had a diastolic pressure of 90 mm. Hg. or higher should have periodic blood pressure determinations made to ascertain whether the diastolic pressure showed a tendency to rise.

A list of references may be obtained by writing The Journal.

Project HOPE'S New Program in Ethiopia

Project HOPE has instituted a new medical teaching and training program in Ethiopia, HOPE's founder and President, Dr. William B. Walsh, has reported. Dr. Walsh commented also that the Ethiopian program will be one of HOPE's largest, with an eventual permanent staff of 100. Physicians and dentists will be flown to Ethiopia to provide essential skills on an abbreviated service basis.

Project HOPE has begun to phase into the activities of the hospital and related activities at Kagnew Station in Eritrea, the northernmost province of Ethiopia. The station is being vacated by the American military, and HOPE will conduct an extensive teaching program in all fields of allied health and support activities. The purpose of the program is to improve the capability of the Ethiopians to provide better and more adequate service to the people of northern Ethiopia.

The Itegue Menen Hospital, a 750-bed unit in Asmara, and the HOPE hospital at Kagnew Station for organization and training purposes are being treated as one unit. The HOPE hospital will be used as a specialized diagnostic center for both inpatients and outpatients and in effect be an annex of the major hospital in the city.

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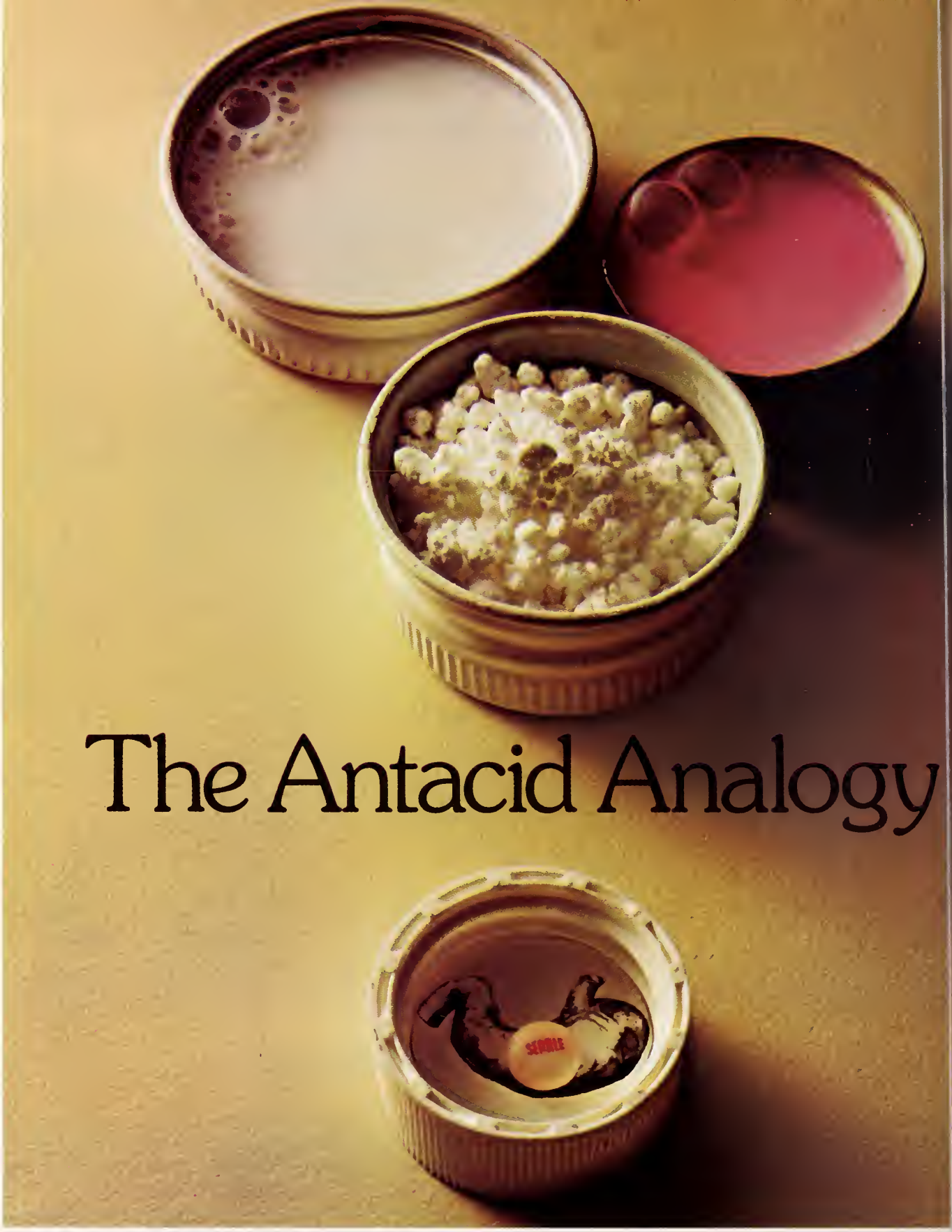

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*Innes, I. R., and Nickerson, M., in Goodman, L. S., and Gilman, A. (editors): The Pharmacological Basis of Therapeutics, ed. 4, New York, The Macmillan Company, 1970, p. 537.

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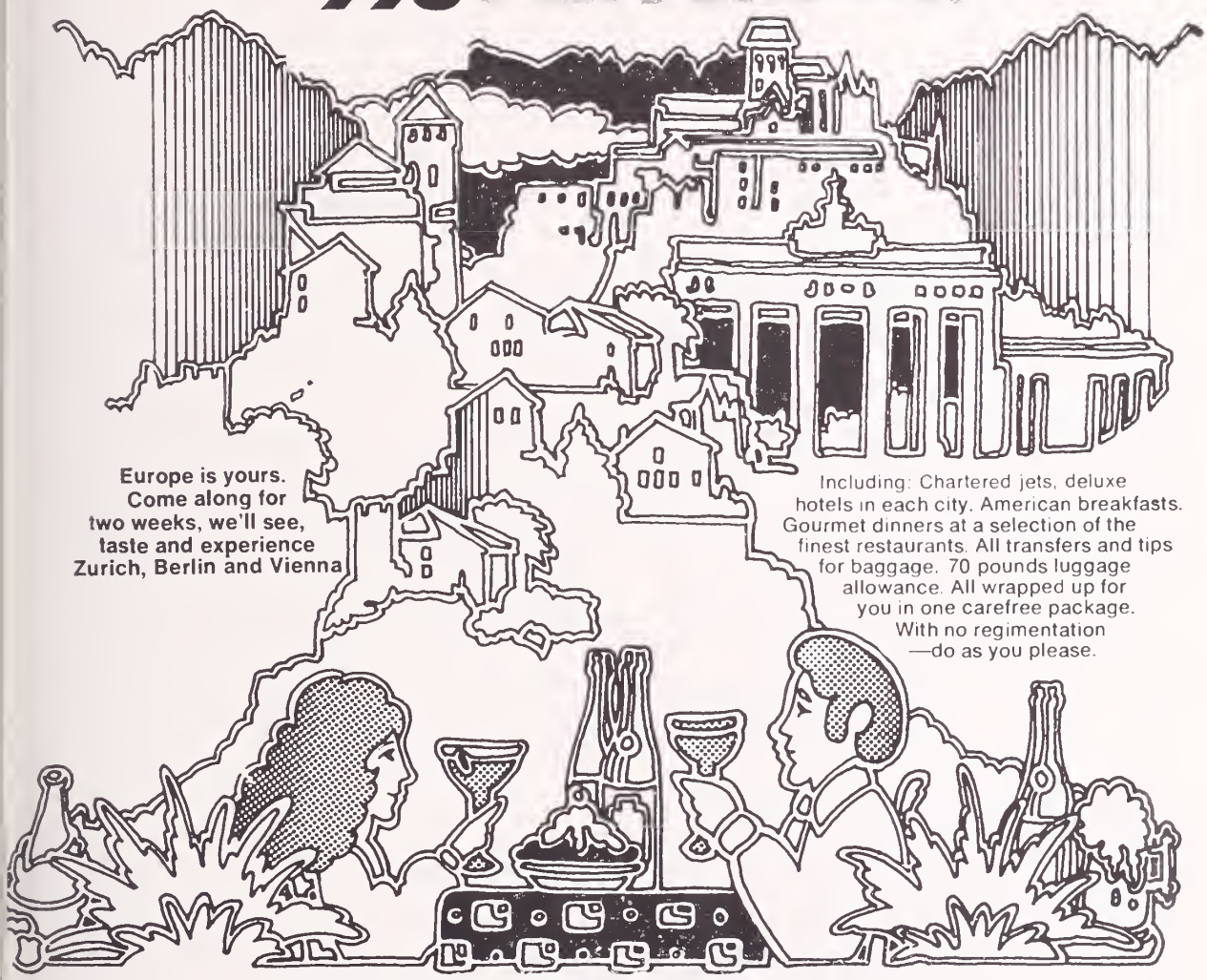

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ONE MAN CAN MAKE A DIFFERENCE!

At long last the Department of Family Practice at West Virginia University is a reality not only with a full-time chief but with residency programs at Charleston, Wheeling and Morgantown fully staffed and ready to start in July. Though the State Medical Association was active and the West Virginia Chapter of the American Academy of Family Physicians most effective in its support, one physician—an orthopedist at that—deserves special mention for his efforts in initiating this new Department.

He painstakingly researched the physician population of West Virginia—developing a comprehensive knowledge of the numbers, locations, countries of origin, specialties and other statistical data. The data suggested that a change of direction of our efforts in medical education in West Virginia was mandatory.

At great personal sacrifice the information was presented before the State Medical Association's WVU Liaison Committee, various legislative committees and sub-committees, the West Virginia Academy of Family Physicians and was published in *The West Virginia Medical Journal.* He is a Clinical Associate Professor of Surgery at WVU—lives in Morgantown and had every reason in the world to remain silent. Granted, most that is happening would have ultimately happened but if he only accelerated the progress by two years it was worthwhile.

Of course, I am talking about Dr. James Hugh Wiley, a West Virginian who loves his State and his University—a dedicated physician and family man, a great outdoorsman and my friend.

Tom McCoy

A. Thomas McCoy, M. D., *President*

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Editor
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122 South Sixth St.
Clarksburg, W. Va.

Managing Editor and
Business Manager
MR. WILLIAM H. LIVELY
Box 1031
Charleston, W. Va. 25324

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EDITORIALS

CONTINUING MEDICAL EDUCATION—A MUST

The West Virginia Chapter of the American Academy of Family Physicians conducted an excellent scientific assembly in Charleston in early April and it was the consensus that it provided a wonderful three-day educational experience for those in attendance.

Dr. William D. Crigger of South Charleston and the members of his program committee are to be congratulated for bringing together a group of highly competent speakers who succeeded in passing along valuable information in the field of continuing medical education which was of interest to the medical practitioners.

It should be pointed out that the 22nd annual session sponsored by the State AAFP Chapter is one of four programs now sponsored annually in West Virginia which provides wonderful opportunities for all physicians to keep abreast of the latest in continuing medical education — a must in this day and age.

Physicians should now look forward to attending the 107th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in August. A fine program has been planned and the list of speakers is impressive. Physicians will be able to obtain education credit for attending the scientific sessions while at the same time being able to enjoy the wonderful recreational facilities at this beautiful resort hotel.

During the month of October the 19th Annual Potomac-Shenandoah Postgraduate Institute in Martinsburg will offer physicians another opportunity to hear papers presented by a number of leading physicians and surgeons from faculties of medical schools in the East.

Also, plans already are being put together for the Eighth Mid-Winter Clinical Conference which will be held in January at the Daniel Boone Hotel in Charleston. Attendance at this Winter session sponsored by the State Medical Association and numerous other groups, has grown each year and the program committee is determined to make the 1975 conference even more interesting and informative to all medical practitioners.

The Journal salutes the dedicated physicians who have devoted many hours planning these medical educational sessions for the benefit of their colleagues in West Virginia.

BLOOD PRESSURE OF SOPHOMORE MEDICAL STUDENTS

Elsewhere in this issue of *The Journal* appears an article on the blood pressure of 688 sophomore medical students, 629 men and 59 women, at West Virginia University School of Medicine between the years 1944 to 1963 inclusive. This report is timely, because presently there is a great deal of interest in screening blood pressure levels of people for evidence of hypertension. The series reported is not large,

but the data have a definite homogenity. The students were all about the same age, all were engaged in the same occupation, all lived approximately in the same environment (the vast majority had lived in West Virginia since birth) and the blood pressures were all taken at the same place and about the same time of day (between 1:30 P.M. and 4:30 P.M.).

The main concern in this study was to scan the height of the diastolic pressure. The American Heart Association holds that for young people the normal upper limit is a systolic pressure of 140 mm. Hg. and a diastolic pressure of 90 mm. Hg. Twenty-seven students (3.9 per cent) had a diastolic pressure of 90 mm. Hg. and 25 (3.6 per cent) a diastolic pressure of more than 90 mm. Hg. Only six students had a systolic pressure of slightly more than 140 mm. Hg.

The article raises the question whether students, about 23 years of age, should have a diastolic pressure of 90 mm. Hg. or higher. There is evidence that young people who have an elevated diastolic pressure may later in life suffer some form of hypertension. It would be well for such people to have their blood pressure checked periodically to ascertain whether the diastolic pressure had risen. If a significant rise occurs, anti-hypertensive medication should be administered, so as to bring both diastolic and systolic pressures within a normal range.

Finally, the article emphasizes that people should be made aware that essential hypertension can be readily controlled. If this is done, dangerous sequelae, such as cardiomegaly, strokes, renal damage and coronary episodes may be greatly lessened. This should be made clear to the public.

GUNSHOT WOUNDS OF THE ABDOMINAL CAVITY

Gunshot wounds of the abdomen unfortunately are still quite common and cause a large number of deaths in the United States each year. About three-quarters of a century ago it was most unusual to operate on patients who had received a gunshot wound in the abdomen. When James A. Garfield, President of the United States, was shot in the abdomen in 1881, the foremost surgeons in the land did not suggest a laparotomy. Whether his life might have been saved had he been operated upon, of course, will never be known. Be all that as it may, the point of view has changed. Many surgeons today believe that a laparotomy should be performed immediately if the patient has received a gunshot wound of the abdomen.

Recently an informative article by Taylor[1] appeared on this subject; the report lists 700 civilian gunshot wounds of the abdomen over a 40-year period (1930-1970). An analysis was made of the per cent of mortality at about seven or eight year intervals (except between the years 1946-1955). The figures given are most meaningful. The mortality between the years 1930-1938 was 52.8 per cent, that is, well over one-half of the patients died from their wounds. Further studies in later years indicate a gratifying decrease in mortality, namely between the years 1938-1946, the mortality 32.6 per cent, and between the years 1955-1962 it was 16 per cent, and finally between the years 1962-1970 it was only 12.7 per cent. The figures are impressive and show how under modern methods of management the lives of many patients who have received gunshot wounds of the abdomen may be saved.

The patients upon admission to the hospital were operated upon immediately, unless it could be shown that the bullet did not enter the abdominal cavity. In making the analysis of the improved mortality Doctor Taylor mentions several contributing factors; among them were: naso-gastric suction tubes, the matter of electrolytic balance and gas exchange and also the importance of a good anesthesia administered by trained people.

He believed that antibiotic agents are really of little use in controlling general peritonitis or abdominal abscess. He does believe, however, that they can be of estimable value in combating the complications of pneumonia, pylephlebitis and pyletitis. He urges that reliance on drugs never be substituted for good surgical treatment.

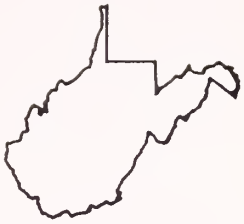
In the final analysis, it is indeed gratifying that excellent progress is being made in the management of gunshot wounds of the abdomen. It is to be hoped that new techniques and other advances be developed which will lower still further the present mortality rate.

[1]Taylor, J. W. Gunshot Wounds of the Abdomen, Ann. Surg. 177: 174, 1973.

'Medical Hotline'

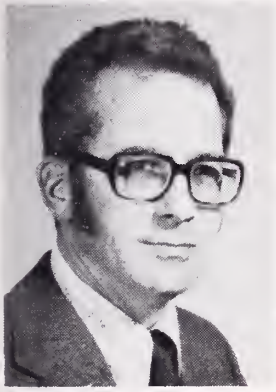
The cooperative health venture between the U.S. and the U.S.S.R. was given added substance with the installation of a "medical hotline," whereby U.S. biomedical investigators can instantaneously trade research knowledge with their Soviet counterparts by teletype. The intercontinental hookup is the first direct communications link with Russia since the famous White House-Kremlin "hotline."

GENERAL NEWS



Drs. Howie and Traubert To Speak At 107th Annual Meeting

Dr. J. Hugh Wiley of Morgantown, Chairman of the Program Committee, has announced that Dr. Virgil M. Howie and Dr. John W. Traubert have accepted invitations to be among the guest speakers at the 107th Annual Meeting of the West Virginia State Medical Association which will be held at The Greenbrier in White Sulphur Springs, August 21-24.



Virgil M. Howie, M. D.

John W. Traubert, M. D.

Doctor Howie will participate in a "Symposium on Newer Concepts in Infectious Diseases" at the first general scientific session on Thursday morning, August 22. His subject will be "Acute Otitis Media."

Doctor Traubert will lead a discussion on the development and future plans for the Department of Family Practice at the West Virginia University School of Medicine at the third general scientific session on Saturday morning, August 24.

Virgil M. Howie, M. D.

Dr. Virgil M. Howie, who is engaged in the private practice of pediatrics in Huntsville, Alabama, is a native of Jackson, Mississippi. He was graduated from Vanderbilt University and received his M.D. degree in 1952 from the Vanderbilt University Medical School.

He interned at the Medical College of Virginia in Richmond, 1952-53, and served a residency in pediatrics at the Los Angeles Children's Hospital, 1955-57. He served as an Instructor in Pediatrics at the Vanderbilt University School of Medicine in 1957. He was certified by the American Board of Pediatrics in 1959 and has been engaged in the practice of pediatrics since that time. His primary interest is in the field of otitis media and he has been a principal investigator for clinical research projects sponsored by a number of pharmaceutical firms.

Doctor Howie is a member of the American Academy of Pediatrics, American Society of Microbiology and the American Society for Clinical Pharmacology and Therapeutics. He is the author or co-author of a number of articles which have been published in scientific journals.

John W. Traubert, M. D.

Dr. John W. Traubert, Chairman of the Department of Family Practice at the West Virginia University School of Medicine, is a native of Wheeling, West Virginia.

He was graduated from West Virginia University and received both his M. S. degree in physiological chemistry and his M. D. degree in 1965 from the Ohio State University School of Medicine. He also served as an instructor in pharmacology and biochemistry while at Ohio State. He interned and served a residency in family practice at Mt. Carmel Hospital in Columbus, 1965-67. He was a recipient of a Mead-Johnson Award in general practice in Columbus.

Doctor Traubert was engaged in family practice in Wellsburg until assuming his present position and is currently serving as President of the Brooke County Medical Society. He also served as health commissioner and coroner in that county. While in the Ohio Valley area, he served as Chairman of the Family Practice section at Wheeling Hospital and was also a member of the staff of the Ohio Valley General Hospital in that city.

Doctor Traubert is a Diplomate of the American Board of Family Practice and was named President Elect of the West Virginia Chapter of the AAFP during its annual meeting in Charleston last month. He has always been active in the West Virginia State Medical Association and is currently serving as Chairman of the WVU Liaison Committee and as a member of the Committee on Medical Education and Hospitals.

Varied Scientific Program Planned

Doctor Wiley announced previously that there would be three general scientific sessions on Thursday, Friday, and Saturday mornings. Among other physicians who have accepted invitations to present papers during the

scientific sessions are Drs. Allen H. Mackenzie, who is a member of the staff of the Division of Medicine — Department of Rheumatic Disease — Cleveland Clinic Foundation and the Cleveland Clinic Hospital; and James F. Glenn, Professor and Chief of the Division of Urologic Surgery at Duke University Medical Center, Durham, North Carolina.

Additional Time for Recreation Planned

Doctor Wiley has emphasized during the past months that the Program Committee is making every effort to schedule the majority of scientific sessions during the morning hours to allow physicians, their wives and guests to enjoy the many recreational facilities available at The Greenbrier after the noon hour.

In addition to the traditional golf and tennis tournament, Doctor Wiley said tentative plans call for a trap and skeet shooting contest as well as a fishing derby.

Business Sessions

Dr. Malcolm C. Todd of Long Beach, California, who will be installed as President of the American Medical Association during the annual meeting in Chicago next month, will speak at the first session of the House of Delegates on Wednesday afternoon, August 21. The Pre-Convention Meeting of the Council will be held that morning.

The final session of the House of Delegates will be held on Saturday afternoon, August 24, at which time Dr. A. Thomas McCoy of Charleston will deliver his Presidential Address.

Sen. Robert C. Byrd to Deliver "Thomas L. Harris Address"

Sen. Robert C. Byrd of West Virginia has accepted an invitation to deliver the "Thomas L. Harris Address" at the opening of the first general scientific session on Thursday morning, August 22.

Additional information concerning the 107th Annual Meeting at The Greenbrier in August will be announced in future issues of *The Journal.*

Dr. James H. Sammons Selected To Be Next AMA Executive VP

The Board of Trustees of the American Medical Association has announced the appointment of James H. Sammons, M. D., as Executive Vice President-designate.

The post of Executive Vice President is the top administrative position at the AMA. Doctor Sammons will succeed Ernest B. Howard, M. D., who has been EVP since March 1969. Doctor Howard will reach retirement age early next year.

Doctor Sammons, a family physician in Baytown, Texas, became Chairman of the AMA Board of Trustees in October 1973. Previously he had served as its Vice Chairman for one year.

AAFP President Sees More Doctors For West Virginia In Future

Two new family practice residency programs being established in West Virginia and a growing national trend toward family practice should help ease the doctor shortage in the Mountain State.

These observations were made by Dr. James G. Price of Brush, Colorado, who was the principal banquet speaker during the 22nd Annual Assembly of the West Virginia Academy of Family Physicians, April 5-7, in Charleston. Doctor Price, who is President of the American Academy of Family Physicians, said he hoped that West Virginia's new family practice residency programs in the Kanawha Valley and Wheeling would soon have 15 recruits a year.

New officers of the West Virginia Chapter of the American Academy of Family Physicians were elected during the 22nd Annual Scientific Assembly in Charleston, April 5-7. They are, from left, Drs. Donald P. Brown of Kingwood, immediate Past President and now Chairman of the Board of Directors; Marshall J. Carper of Charleston, Treasurer; William D. Crigger of South Charleston (seated), President; Ray M. Kessel of Logan, Vice President, and Margaret I. Stemple of Morgantown, Secretary.

The West Virginia Academy elected as President-Elect Dr. John W. Traubert, Chairman of the newly established Department of Family Practice at the West Virginia University School of Medicine.

Other officers elected were Drs. Ray M. Kessel of Logan, Vice President; Margaret I. Stemple of Morgantown, Secretary, and Marshall J. Carper of Charleston, Treasurer.

Dr. William D. Crigger of South Charleston will serve as Academy President for the coming year. The new President is a graduate of Marshall University and the Temple University School of Medicine. He interned at Charleston General and set up his medical practice in 1951 in South Charleston. He and his wife, Doris, are the parents of five children.

Dr. George W. Hogshead of Nitro was elected to replace Doctor Carper as District Eight Director for the Academy. Dr. T. L. Ritz of Wheeling became the new Director for District One. Drs. Joseph A. Smith of Dun-

bar and Del Roy R. Davis of Kingwood were named State delegates to the national meeting next October in Los Angeles. Retiring President Dr. Donald P. Brown of Kingwood will serve this year as Chairman of the Board of Directors.

Special guests during the annual meeting included five young doctors who will be the first trainees in the family practice residency program in the Kanawha Valley beginning July 1.

Shown during the 22nd Annual Scientific Assembly of the West Virginia Chapter of the American Academy of Family Physicians are, from left, seated, Drs. James G. Price of Brush, Colorado, President of the American Academy of Family Physicians; John W. Traubert, President-Elect of the State Chapter and Chairman of the Department of Family Practice at the West Virginia University School of Medicine, and Carl B. Hall of Charleston, Chairman of the National AAFP Board of Trustees; standing, from left, Drs. Joseph A. Smith of Dunbar and Del Roy R. Davis of Kingwood, State Delegates to the AAFP, and Richard E. Flood, of Weirton, retiring Chairman of the Board of Directors and a Past President of the State Chapter.

Dr. C. Carl Tully of South Charleston, Director, said all of the prospective trainees plan to establish their future medical practices in West Virginia.

Selected for training were Richard D. Hayes of Nitro, William L. Harris of Fenwick, in Nicholas County; John P. MacCallum of Madison, Donald A. Blum of New Martinsville and James Kwako of Bismarck, North Dakota, a transfer student to this state.

The facilities of Herbert J. Thomas Memorial Hospital in South Charleston, and the Charleston Area Medical Center will be utilized in the training program.

Doctor Price, in his banquet address, said the AAFP has a goal "of persuading 25 per cent of all medical school graduates in the years ahead toward family practice."

"I have confidence that goal will be reached," he commented. Doctor Price said that AAFP research shows that young doctors are moving away from big cities to smaller communities and rural areas to establish their medical practices.

"There is a growing social conscious awareness among young doctors. Their interest in the environment, ecology, pollution and other factors affecting the quality of life is affecting their moves toward the smaller communities."

Doctor Price said he did not believe all small towns will get a doctor. Today's trend is toward group practices established in "population pools" which may embrace more than one community or county, he said.

During the three-day meeting the State chapter formally endorsed the candidacy of Dr. Carl B. Hall of Charleston as the next President-Elect of the AAFP. He is now serving as Chairman of its Board of Trustees.

The family physicians heard 14 medical authorities offering instruction in a wide range of topics — from heart disease to the emotional effects of a chronic ailment on children and families.

Dr. Richard E. Flood of Weirton, Chairman of the Board of Directors, presided at the business sessions.

Doctor Traubert will assume the presidency of the 300-member group during the 1975 meeting, April 4-6, in Morgantown.

AAFP 'Hot Line' Helps Students Find Family Practice Slots

A "hot line" service conducted recently by the Education Division of the American Academy of Family Physicians offered an unprecedented service to senior medical students seeking first-year slots in Family Practice residency programs.

According to the April issue of the *AAFP Reporter*, the "hot line" service was devised after an Academy survey revealed that almost 1,000 students interested in Family Practice residency positions could not be "matched" in the National Intern-Resident Matching Program (NIRMP) because of lack of Family Practice spaces. The "hot line" service was timed to follow immediately after results of the NIRMP were announced to students.

Education Division staffers who manned the three "hot line" telephones — answering more than 250 calls during the seven-day period — served as information "brokers," directing student callers to programs with openings and furnishing interested program directors with students' names.

They were able to give students the names of residencies who had upped the number of openings available after obtaining funds from a $10,000,000 supplement released by the federal government in early March. The supplement, which went to approved Family Practice residencies only, came from previously impounded HEW monies.

Openings in programs not approved in time to meet the NIRMP deadline provided an additional source of first-year spaces.

Physicians and Wives Candidates For Legislative Seats

Three members of the West Virginia State Medical Association and the wives of three members are seeking nominations for seats in the West Virginia Legislature in the May 14 primary election.

Drs. Albert C. Esposito and Willard F. Daniels, Jr., both of Huntington, and Dr. Hawey A. Wells, Jr., of Princeton, are candidates for the House of Delegates.

Mrs. Charles W. Merritt of Beckley, who has served two terms as a member of the House of Delegates, has filed as a candidate for the State Senate from the Ninth District. Her opponent will be the incumbent, Alan L. Susman, also of Beckley.

Mrs. John A. B. Holt of Charleston, who completed her first term as a Delegate from Kanawha County, also has filed for reelection. Mrs. William D. Crigger of South Charleston will be running for a first term as a member of the House of Delegates.

Monitoring Births

The U. S. Department of Health, Education and Welfare developed plans to maintain a computer monitoring system that will process data on some one million births a year.

Under the direction of the Center for Disease Control in Atlanta, this project will survey more than 1,500 hospitals with the intent of detecting and following up unusual patterns in the occurrence of birth defects that may suggest environmental causes. When an unusal pattern occurs, the CDC will work through state and local health departments and physicians to pinpoint the causes.

The Continuing Medical Education program of the Veterans Administration Center at Martinsburg was surveyed at the hospital on March 26 by the State Medical Association. From left, seated, are Drs. Hu C. Myers of Philippi, a member of the survey team; Henry Lee Butler, Chief of Staff, and Del Roy R. Davis of Kingwood, Chairman of the survey team; standing, Dr. Vicken V. Kalbian, Acting Associate Chief of Staff for Research and Education, left, and Mr. Paul D. Luttrell, Administrative Assistant to the Chief of Staff. Results of the survey will be announced following the next meeting of the State Medical Association's Committee on Medical Education and Hospitals.

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled in the coming months.

1974

May 1-3—Am. Surg. Assn., Colorado Springs.
May 1-4—W. Va. Chapter, ACS, White Sulphur Springs.
May 10-11—Sem. In Emerg. Med., Charleston.
May 12-15—Am. Thoracic Soc., Cincy.
May 12-15—S. Carolina Med. Assn., Myrtle Beach.
May 12-15—Ohio State Med. Assn., Cleveland.
May 12-16—Am. Assn. Plastic Surgeons, Seattle.
May 16-18—Childhood Cancer, Dallas.
May 17-18—Am. Assn. Clin. Urologist, St. Louis.
May 18—Symp. On V.D., Wash., D.C.
May 19-22—Am. Ophthal. Soc., Hot Springs, Va.
May 22—Am. Soc. Gastrointestinal Endoscopy, San Francisco.

June 3-6—Int. Convo. Immunology, Buffalo, N. Y.
June 9-13—International Thyroid Conf., Boston.
June 10-12—Am. Neuro. Assn., Boston.
June 11-14—Soc. of Nuclear Med., San Diego.
June 15-16—Am. Diabetes Assn., Atlanta.
June 20-21—Soc. for Vascular Surgery, Chicago.
June 22-23—Am. Assn. Study of Headache, Chicago.
June 23-27—AMA, Chicago.
June 24-26—Am. Coll. Preventive Med., Chicago.

July 10—Breast Feeding Sem., Chicago.
July 14-20—Radiation Research Soc., Seattle.
July 25-27—Am. Electroencephalographic Soc., Seattle.
July 28-Aug. 1—Natl. Med. Assn., N. Orleans.
July 28-Aug. 2—Int. Assn. Child Psychiatry & Allied Professions, Phila.

Aug. 2-4—International Doctors in AA, O'Hare Airport (Inn).
Aug. 12-15—Am. Hosp. Assn., Chicago.
Aug. 21-24—107th Annual Meeting, W. Va. State Medical Assn., White Sulphur Springs.

Sept. 4-7—Am. Assn. Ob.-Gyn., Hot Springs, Va.
Sept. 9-11—AMA Congress Occupat. Health, Chicago.
Sept. 16-19—Ky. Med. Assn., Louisville.
Sept. 18-20—Int. Symp. Epidemiology of Hypertension, Chicago.
Sept. 18-21—Am. Thyroid Assn., St. Louis.
Sept. 27-28—Am. Heart Assn., W. Va. Affiliate, Annual Meeting & Scientific, Wheeling.

Oct. 6-10—Am. Acad. Oph. & Otol., Dallas.
Oct. 14-17—AAFP, L. A.
Oct. 19-24—Am. Acad. Pediatrics, San Fran.
Oct. 21-25—ACS Clinical, Miami Beach.
Oct. 29-30—Am. Assn. Study of Liver Diseases, Chicago.

1975

Jan. 24-26—8th Annual Mid-Winter Clinical Conf., Charleston.

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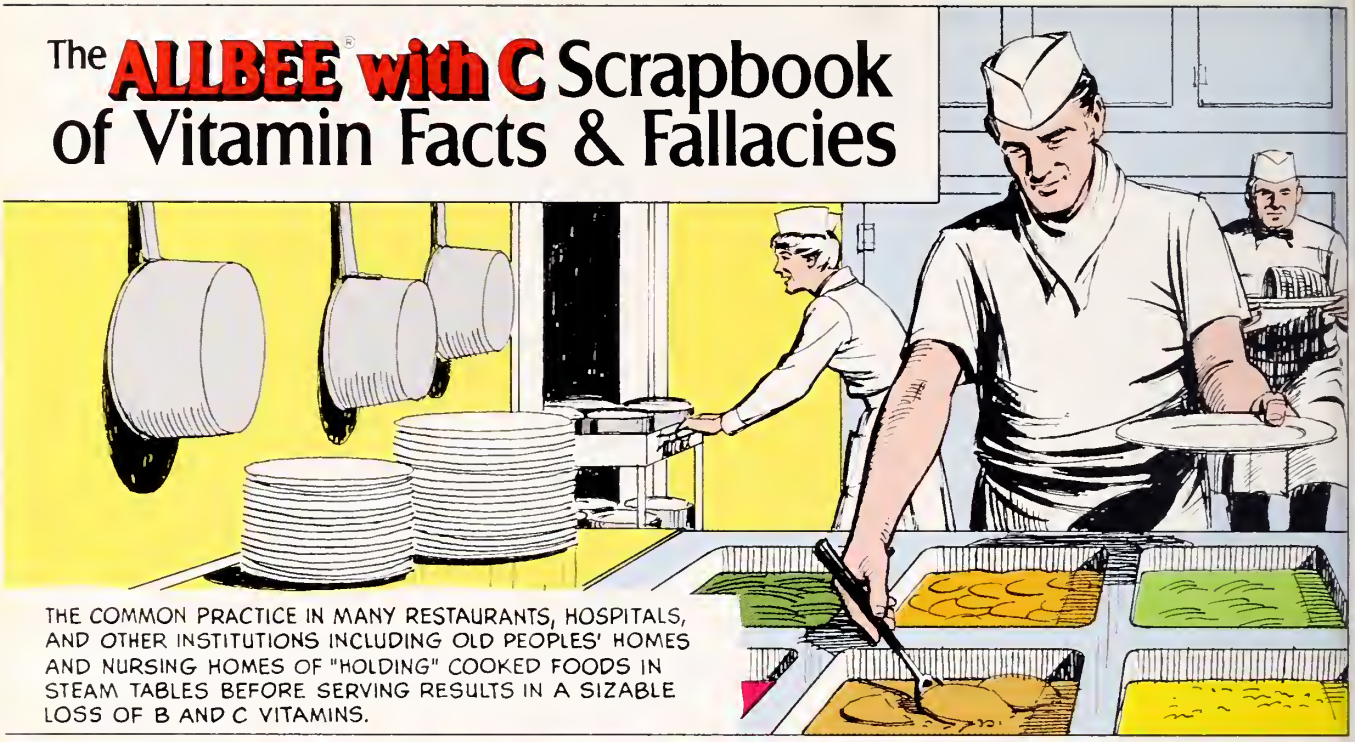

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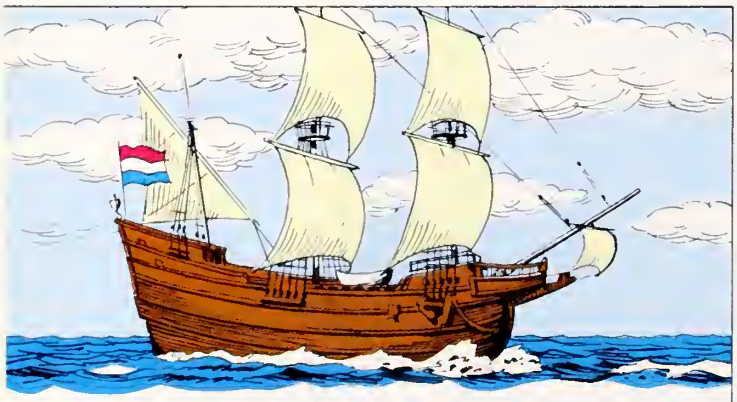

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WVU Medical Center
–News–

INTERNSHIPS or residencies will begin July 1 for the 73 men and four women who will graduate May 19 from West Virginia University School of Medicine.

Results of the computerized system (National Intern and Resident Matching Program) that pairs senior medical students and hospitals according to the choices of both show that more than one-third of the 77 WVU-educated new physicians will remain in West Virginia for their internship or first year of residency.

Other states and countries that attracted the prospective graduates include: Virginia (8), North Carolina, Ohio and Pennsylvania (5 each), Florida (4), California, Missouri, North Dakota and Texas (2 each), and Canada, Colorado, District of Columbia, Illinois, Indiana, Louisiana, Maryland, Massachusetts, South Carolina, Tennessee, Washington and Wisconsin (1 each).

Compared to just two in the Class of 1973, 12 members of this year's class have chosen family practice residencies. The other types of internships and residencies chosen and the number in each are: medicine (28), rotating (19), surgery (8), psychiatry (6), obstetrics and gynecology (3) and pathology (1).

Members of the Class of 1974, their home towns, and the hospitals where they will take additional training are:

Charles T. Adkins, Pineville, Barnes Hospital Group, St. Louis; David R. Almond, Buckhannon, WVU Department of Behavioral Medicine and Psychiatry; Robert R. Arrington, Huntington, University of Miami (Fla.) Affiliated Hospitals; Gary A. Bailey, Beckley, and Roger P. Bennett, Bolair, Charleston Memorial Hospital; Timothy J. Blanchat, Marion, Virginia, Ochsner Foundation Hospital, New Orleans; Donald A. Blum, New Martinsville, Kanawha Valley Family Practice Program.

John H. Brooks, St. Albans, Harrisburg (Pa.) Polyclinic Hospital; James F. Byer, Huntington, Riverside Methodist Hospital, Columbus, Ohio; Daniel L. Cassis, Charleston, University of Miami (Fla.) Affiliated Hospitals; Curtis A. Chambers, Charleston, Bayfront Medical Center, St. Petersburg, Florida; David F. Colvin, Kenova, WVU Department of Behavioral Medicine and Psychiatry; Polly H. Cunningham, Beckley, and William N. Cunningham, Charleston, University of Virginia Hospital, Charlottesville; Michael L. Davis, Parkersburg, Naval Hospital, Portsmouth, Virginia.

David A. DeHart, Huntington, Charlotte (N. C.) Memorial Hospital; James R. Dilley, Marlinton, Medical College of Virginia, Richmond; Joan P. Donley, Wellsburg, Baylor University, Houston, Texas; Samuel C. Dotson, III, Morgantown, and Harry E. Duncan, Jr., South Charleston, Charleston Memorial Hospital; Daniel E. Gabriel, Jr., Pennington Gap, Virginia. Roanoke (Va.) Memorial Hospital; Claudia A. Goodwin, Bridgeport, WVU Department of Medicine; Michael W. Hanson, Twin Branch, Riverside Methodist Hospital, Columbus, Ohio; Kenneth M. Harman, Kline, Navy Hospital, San Diego.

William L. Harris, Fenwick, and Richard D. Hayes, Jr., Nitro, Kanawha Valley Family Practice Program; David W. Heilman, Charleston, Shadyside Hospital, Pittsburgh; Ray L. Henderson, Logan, Cleveland (Ohio) Metropolitan General Hospital; Charles W. Hendricks, Madison, and John S. Hill, Charleston, Charleston Memorial Hospital; Ronald C. Hill, Parkersburg, Duke University Medical Center; Dennis L. Hoak, Huntington, St. Vincents Hospital, Worcester, Massachusetts; Charles R. Honaker, Huntington, and Thomas A. Horsman, Bim, Charleston Memorial Hospital; Brian D. Houston, Bridgeport, North Carolina Baptist Hospital, Winston-Salem.

John P. Hutton, Clarksburg, WVU Department of Behavioral Medicine and Psychiatry; Betty Hull Johnson, Fairmont, and Donald G. Johnson, Kopperston, Montefiore Hospital, Pittsburgh; Arthur E. Kelley, Morgantown, WVU Department of Behavioral Medicine and Psychiatry; Thomas G. Kenamond, Wheeling, Duke University Medical Center; Michael J. Lewis, Charleston, WVU Department of Family Practice; Hugh A. Lindsay, Morgantown, WVU Department of Obstetrics and Gynecology; Richard D. Lindsay, Martinsburg, Charleston Memorial Hospital; Christopher M. Lothes, South Charleston, Roanoke (Va.) Memorial Hospital; Dale J. Luketich, Weirton, WVU Department of Family Practice.

John P. MacCallum, Madison, Kanawha Valley Family Practice Program; Michael F. McCagh, Springfield, WVU Department of Medicine; Lloyd P. McGinnis, Reedsville, USAF Medical Center, Scott AFB, Illinois; Lawrence F. Martin, Vanderbilt, Pennsylvania, WVU Department of Medicine; John T. Matthews, Charleston, Vanderbilt University Affiliated Hospitals, Nashville, Tennessee; Philip P. Metzger, Elizabethtown, Pennsylvania, Harrisburg (Pa.) Polyclinic Hospital; Thomas

(Continued On Page xiii)

- **Compiled from material furnished by Mrs. Mary Ellin Wylie, Director, Medical Center News and Information Services, Morgantown, W. Va.**

WVU MEDICAL CENTER—(Continued)

S. Miller, Fairmont, Charleston Memorial Hospital; David W. Nesselroade, Williamstown, WVU Department of Family Practice; David A. Orenberg, Parkersburg, Kaiser Foundation Hospital, Oakland, California; Lawrence H. Phillips, II, Weirton, University Hospitals, Madison, Wisconsin; Gregory J. Post, Fargo, North Dakota, St. Luke's Hospital, Fargo; John D. Richmond, Beckley, Presbyterian Hospital, Denver.

Kenrick H. Roberts, Wheeling, WVU Department of Medicine; Peter R. Roberts, Elkins, Toronto (Canada) General Hospital; Charles I. Rogers, Morgantown, Medical Center Hospitals, Charleston, South Carolina; Larry C. Rogers, Chesapeake, Charleston Memorial Hospital; Robert J. Rose, Lead, South Dakota, Sacred Heart Hospital, Spokane, Washington; Darrel F. Saunders, Jr., Morgantown, St. Louis (Mo.) Group Hospitals; Robert K. Scott, II, Logan, Charles F. Kettering Hospital, Kettering, Ohio; William G. Short, Mullens, Jacksonville (Fla.) Educational Program; George E. Snider, Jr., Bluefield, Roanoke (Va.) Memorial Hospital.

Gary F. Steele, St. Albans, Charleston Memorial Hospital; Robert D. Stewart, Dunbar, Duke University Medical Center; John G. Tellers, Chaska, Minnesota, and David E. Vincent, Fairmont, WVU Department of Behavioral Medicine and Psychiatry; Thomas G. Wack, Jr., Wheeling, Memorial Hospital of South Bend, Indiana; Richard C. Walker, Morgantown, Akron (Ohio) City Hospital; Rome H. Walker, Charleston, Roanoke (Va.) Memorial Hospital; Randall L. Waterman, Forman, North Dakota St. Luke's Hospital, Fargo, North Dakota; Gordon D. Willey, Huntington, Brooke Army Hospital, San Antonio; David L. Williams, Morgantown, Washington (D.C.) Adventist Hospital; Larry B. Wilshire, Chelyan, Naval Hospital, Bethesda, Maryland.

National Blood Program

The major blood banking groups and the American Medical Association began in late 1973 to develop plans for the implementation of a voluntary national program for collecting and dispersing blood.

By the end of the year, two preliminary plans had been proposed—one developed by the AMA and the other jointly by the American Association of Blood Banks (AABB), the American National Red Cross (ANRC), and the Council of Community Blood Centers (CCBC).

The AMA's implementation plan would organize blood banks and transfusion facilities they serve within a national system that retains regional and local responsibilities and authority. Under this plan, voluntary nonprofit blood banks of appropriate size able to provide a full range of services would be considered eligible for official designation as regional centers.

The AABB-ANRC-CCBC plan provided for a broadly based, unified American Blood Commission to implement the national blood policy. Blood resource groups, transfusion services, and physicians who order the blood would be strongly represented on the commission. There would also be input from consumer, labor, and business groups.

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The Month in Washington

THE American Medical Association is playing a guiding role in an attempt to establish an American blood commission that would assure a national, all-volunteer supply of blood for transfusions and medical emergencies by December 31, 1975.

The plan was made public by Richard E. Palmer, M.D., now Chairman of the AMA Board of Trustees, and spokesman for the major groups involved in collecting, distributing and using blood at a press conference in the AMA-Washington office.

Other major sponsors of the proposed American Blood Commission include the American National Red Cross, the American Association of Blood Banks, and the Council of Community Blood Centers.

The proposed plan is for a volunteer program controlled at the local level, with medical societies playing a major role. Some 150 national groups with an interest in a safe blood supply would be members of a commission that would oversee each regional program. The regional programs in turn would guide the activities of blood banks and transfusion facilities in their own area.

Last fall the Administration warned that if the private sector could not reach agreement on a national program a federally-mandated program would be sought from the Congress. The AMA stepped in and mediated the sharply different approaches advocated by the major blood groups.

The major difference had pitted a for-profit against non-profit blood supply. In the non-profit field, the American Association of Blood Banks (AABB) and the American National Red Cross have vied for the leadership role. The non-profit blood banks—largely hospital units—chiefly have favored a non-replacement fee for blood as the most dramatic way of attracting donors, whereas the Red Cross traditionally has relied on strictly volunteer blood.

Under the proposed plan, the for-profits would be out in the cold. The hope is that a non-replacement fee system will not be needed, though it would be permitted.

The AMA-proposed plan has been published in the Federal Register in order to give interested groups time to comment. At a later date HEW will sponsor a conference to consider comments and decide a course of action.

Commenting on the proposal, Doctor Palmer told the news conference it "builds on the strengths of the pluralistic system."

- **From the Washington Office of the American Medical Association.**

"These partners in the American Blood Commission can communicate the medical necessity of a dependable blood supply to the general public from which volunteer donors must come," he said. "The systematic coordinated recruitment of volunteer donors called for by this plan depends on a receptive public attitude.

"By the end of 1975 every blood bank associated with one of the three major blood banking organizations expects to be drawing 100 per cent of their blood supply from volunteer donors," Doctor Palmer said.

AMA Warns Against 'Health Care Czar'

The American Medical Association has warned Congress that legislation before it would treat the health sector as "one vast, monolithic public utility" with the Secretary of Health, Education and Welfare "a health care czar."

Testifying before the Senate health subcommittee on a bill sponsored by Senator Edward M. Kennedy, (D-Mass.), AMA President Russell B. Roth, M.D., termed the bill "one of the gravest steps to be proposed concerning health care delivery." The measure calls for replacement of Comprehensive Health Planning and Regional Medical Programs by a formal planning system coupled with public utility regulations by state health commissions under HEW supervision. "We are opposed to the creation of public utility type regulatory controls and the planning mechanisms in this and similar measures," Doctor Roth said.

The bill before the Senate health subcommittee calls for a formal system of planning coupled with public utility regulation by state health commissions under the supervision of the HEW Department. It is part of a comprehensive measure extending certain public health service programs and making sweeping changes in the nature of the present Comprehensive Health Planning and Regional Medical Programs.

"In our view this extreme measure is unwarranted, without justification based on either experience or need. It carries serious potential for impeding a beneficial development of medical care," Doctor Roth said.

He termed the bill an "unprecedented federal in-

(Continued On Page xvi)

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Milton J. Lilly, Jr. M.D.
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Robert E. O'Connor, M.D.
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Moseley H. Winkler, M.D.
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Nancy McClung, M.S.

Anesthesia

Catherine Kenney, CRNA
Inez Maggio, CRNA
Muriel Dodds, CRNA

Obituaries

GLENN ASHWORTH, M. D.

Dr. Glenn Ashworth of Buckhannon died on February 19 in a Virginia hospital. He was 62.

A native of Upshur County, Doctor Ashworth was a graduate of West Virginia University and received his M. D. degree in 1937 from Rush Medical College in Chicago.

Survivors include the widow, one son, Eric Ashworth of Flushing, Michigan; two daughters, Mrs. Thomas B. Yost of Atlanta and Mrs. William W. Brown of Columbus, Ohio; two sisters, Mrs. Freda McClain of New Milton, in Doddridge County, and Mrs. Lewis Pickett of Morgantown; and two brothers, Dr. Wease L. Ashworth of Buckhannon and John Ashworth of Akron, Ohio.

° ° ° °

ISADORE E. BUFF, M. D.

Dr. Isadore E. Buff of Charleston, an early crusader for clean air and black lung benefits for coal miners, died on March 14 in a Charleston hospital. He was 65.

Born in Utica, New York, he moved a year later with his parents to Charleston.

Doctor Buff was a graduate of West Virginia University and received his M. D. degree in 1931 from the University of Louisville school of Medicine. He interned at the Chesapeake and Ohio Hospital in Huntington.

A veteran of World War II, he was a member of the Kanawha Medical Society, the West Virginia State Medical Association and the American Medical Association.

Surviving are two daughters, Dr. Judy Buff of Cincinnati and Mrs. Dolly Bromberg of Raleigh, North Carolina; and two sisters, Mrs. Al Trope of Miami, Florida and Mrs. Jack Goldberg of Hollywood, Florida.

° ° ° °

JAMES E. GRACE, M. D.

Dr. James E. Grace of Chelyan, was dead on arrival at a Charleston hospital on February 25. He was 62.

Doctor Grace was a family physician and a medical consultant for the West Virginia Division of Vocational Rehabilitation. He was a graduate of West Virginia University and received his M. D. degree in 1938 from the Medical College of Virginia.

Survivors include one son, James Eugene Grace, Jr. of Hampton, Virginia; two daughters, Mrs. Alice Lee Kearns of Charlotte, North Carolina and Mrs. Richard R. Heath of Charleston; a brother, Dr. Warren L. Grace of Chesapeake, in Kanawha County, and a sister, Mrs. Robert Gleason of Nederland, Texas.

° ° ° °

NICHOLAS F. SABBAGH, M. D.

Dr. Nicholas F. Sabbagh of Hudson Falls, New York, formerly of Ansted, in Fayette County, died recently in New York. He was 81. He also had practiced in Raleigh and Preston Counties.

Doctor Sabbagh, who moved to Hudson Falls in 1971, was a native of Sidon, Lebanon. He was a graduate of American University in Beirut, Lebanon and received his M. D. degree in 1916 from New York Medical College. He interned at St. Catherine's Hospital in Brooklyn and did postgraduate work in obstetrics and gynecology at the University of Paris and Baudelocque Clinique in Paris, France.

Doctor Sabbagh was a member of the Preston County Medical Association, the West Virginia State Medical Association and the American Medical Association.

° ° ° °

ISAIAH W. TAYLOR, M. D.

Dr. Isaiah W. Taylor, former Huntington family physician, died on February 28 in Fort Lauderdale, Florida at his home. He was 91.

Born in Freeman, in Mercer County, Doctor Taylor attended Concord State College and West Virginia University, receiving his M. D. degree in 1910 from the Medical College of Virginia.

He was an honorary member of the Cabell County Medical Society, the West Virginia State Medical Association and the American Medical Association.

Surviving are the widow, one son, Dr. I. Ewen Taylor of Huntington; three brothers, Jesse of Roseland, Florida, Levi of Beckley and John M. of Matoaka, in Mercer County; and three sisters, Mrs. Ada T. Bailey of Matoaka, Mrs. J. S. (Bertha) Hall of Middletown, Virginia and Mrs. Cora T. Painter of Princeton.

MONTH IN WASHINGTON—(Continued)

volvement in matters which, under our federal system, have traditionally resided in state and local governments.

"We must caution against the imposition of a massive bureaucratic control of the health care system. The expertise within governmental bureaucracy must be questioned. We cannot afford to institute a system which can stifle meaningful competition, innovation and development of appropriate health care services and facilities. The economic forces inherent in this proposal could defeat the intention of this committee to foster the developments of improvements in our health care delivery system."

A major provision of the legislation would require the state health commissions "to determine prospectively rates used for reimbursement purposes for health services of health care providers within the state and regulate all reimbursements if such health care providers made on either a charge, cost, negotiated, or other basis and review such rates at least once a year."

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County Societies

CABELL

Dr. Hans Weill was guest speaker at the meeting of the Cabell County Medical Society on March 14. Doctor Weill, who is Professor of Medicine at Tulane University School of Medicine, discussed "Clinical Problems of Occupational Lung Disease."

Dr. James R. Cook gave a progress report on the Committee for Physician Recruitment and distributed samples of a new physician-recruitment brochure for the Huntington area.—F. Maia, M. D., Acting Secretary.

* * * *

McDOWELL

The McDowell County Medical Society met on March 13 at Doctor's Memorial Hospital in Welch.

Dr. Mario S. Cardona, President, announced committee appointments for 1974.

A film on "Cancer of the Urinary System" was presented.—Arthur A. Carr, M. D., Secretary.

* * * *

MERCER

Dr. T. Keith Edwards of Bluefield gave an interesting presentation on the laparoscope at the meeting of the Mercer County Medical Society on March 18 at the Dinner Bell Restaurant in Princeton. A movie on the use of the culdoscope and the laparoscope also was shown.

A donation of $100 to Camp Kno-Koma for diabetic children was approved.—John J. Mahood, M. D., Secretary.

* * * *

MONONGALIA

Doctor G. Robert Nugent of the West Virginia University Medical Center presented the scientific program at the meeting of the Monongalia County Medical Society on March 5 at the Old Mill Club in Morgantown. Doctor Nugent spoke on his method of treatment of trigeminal neuralgia—the use of radio frequency current to destroy fibers of the trigeminal nerve. His success with this operation has won him international recognition.

Dr. Richard V. Lynch, Jr., a member of the Facilities Review Committee for Region VI and also the Governor's Appointee to the State Comprehensive Health Planning group, was given authority to vote for the construction of a new 250-bed Monongalia General Hospital to replace the two present hospitals.

It was reported that construction of a new County Health Building should begin around April 1.

A gift of $300 to Camp Kno-Koma for diabetic children was approved.—H. Summers Harrison, M. D., Secretary.

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Cigarette Consumption Declines, But Smoking Still With Us

Cigarette consumption has declined since the U. S. Surgeon General's First Report on Smoking and Health 10 years ago, but smoking is still with us and the effects related to smoking remain as significant health problems.

This is the conclusion of "Progress Review for Controlling Smoking," written last month by N. H. Dyer, M. D., West Virginia State Director of Health, for a bi-weekly publication issued by the State Department of Health.

Research on the relationship of smoking and disease has been devoted to a wide variety of concerns ranging from such specialized investigations as the Quantitative Chromatographic Determination of Maleic Hydrazide in Cigarette Smoke to studies trying to learn the connection between smoking and face wrinkles.

One British firm, assuming the habit of smoking will always continue, has been developing a tobacco substitute, N.S.M. (New Smoking Material), derived from wood pulp which is supposed to be less irritating and cause less skin cancer among experimental mice. A large amount of research has been concentrated on the leading causes of death among U. S. citizens: heart disease, diseases of the blood vessels and cancer.

Some noticeable changes which have occurred in altering or controlling smoking practices during the last 10 years include:

Ban on advertising cigarettes on television, labeling of cigarette packages with possible health hazard warning, separation of smoking and non-smoking passengers on airplanes, and prohibition of smoking in public meeting places as offices and board rooms.

200 Packs Per Person

Cigarette consumption seems to have leveled off at around 200 packages per person per year, according to a report presented at the National Tobacco Workers Conference last year. It also predicts a gain in consumption if concern over smoking and health declines or if a safer cigarette is developed.

The most encouraging results in controlling smoking have been in stopping youngsters from smoking before they start. Investigators have found that only about two per cent of youngsters smoke because they actually enjoy the taste of a cigarette. The desire to smoke has to be acquired and it usually starts at an age of 16 or 17.

Change of Address

Members of the West Virginia State Medical Association are requested to notify the headquarters offices promptly concerning any change in address. Notices should be mailed to Box 1031, Charleston, West Virginia 25324.

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WANTED—Full-time Public Health Physician for Cabell-Huntington Health Department, Huntington, West Virginia. Opening available immediately. Contact Mr. Ernest Leaberry, President, 1336 16th Street, Huntington, W. Va. 25701.

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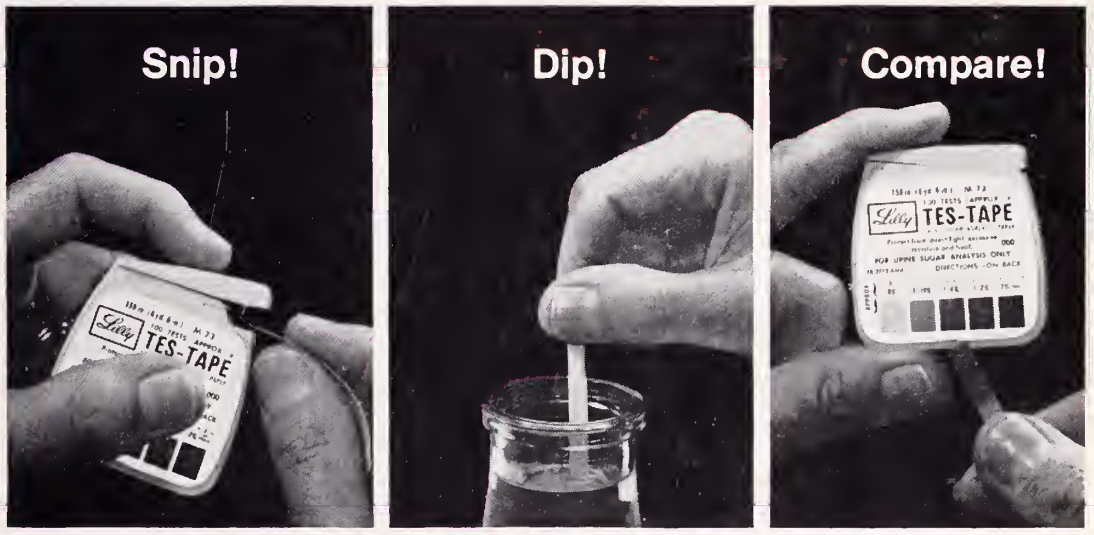

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two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

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For further information on this subject, the following references are provided:

1. Henry BW, *et al: Dis Nerv Syst 30*:675-679, Oct 1969.
2. Hollister LE, *et al: Arch Gen Psychiatry 24*:273-278, Mar 1971.
3. Claghorn J: *Psychosomatics 11*:438-441, Sept-Oct 1970.

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si , or with suicidal tendencies.

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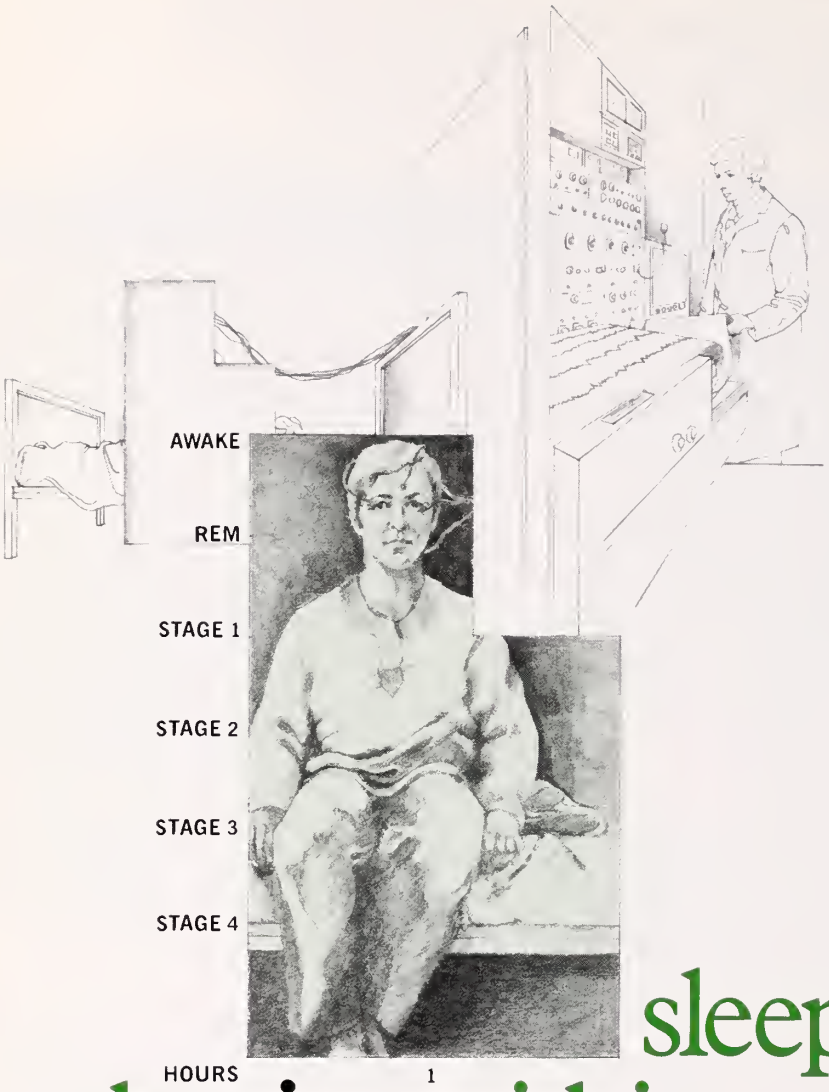

sleep begins within 17 minutes, on average ...

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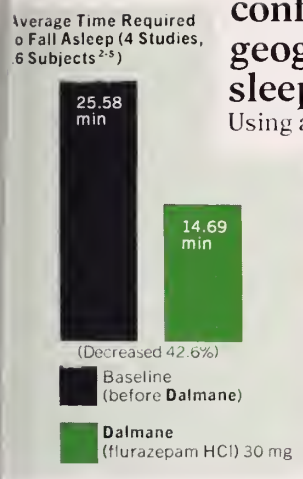
proved by a 22-night clinical study of insomnia patients in the sleep research laboratory and at home[1]

Three insomnia patients selected for difficulty falling asleep were administered Dalmane (flurazepam HCl) 30 mg for 14 consecutive nights. Placebo was given for four nights prior to and four nights after Dalmane. Physiologic tracings on Dalmane nights 1-3 showed sleep induction time averaged 13.90 minutes; on Dalmane nights 12-14, 18.80 minutes. Combined average for the 6 monitored drug nights was 16.35 minutes.[1]



confirmed by clinical studies in four geographically separated sleep research laboratories[2-5]

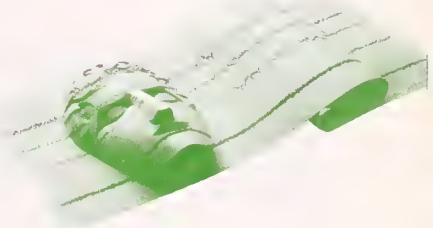
Using a 14-night protocol involving eight insomniac and eight normal subjects, four studies confirmed the sleep-inducing effectiveness of Dalmane (flurazepam HCl) and the reproducibility of this response. On average, one 30-mg capsule induced sleep within 17 minutes. In all these studies, Dalmane induced sleep rapidly, reduced nighttime awakenings, and provided 7 to 8 hours of sleep without repeating dosage.[2-5]

Dalmane (flurazepam HCl) induces and maintains sleep, with relative safety

Dalmane is generally well tolerated; morning "hang-over" has been relatively infrequent. While dizziness, drowsiness, lightheadedness and the like have been noted most often, particularly in the elderly and debilitated, physicians should be aware of the possibility of more serious reactions, as noted below.

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.
Contraindications: Known hypersensitivity to flurazepam HCl.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.
Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.
Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.
Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.
Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.



when restful sleep is indicated

Dalmane®
(flurazepam HCl)

One 30-mg capsule *h.s.* — usual adult dosage (15 mg may suffice in some patients).
One 15-mg capsule *h.s.* — initial dosage for elderly or debilitated patients.

- **induces sleep within 17 minutes, on average**
- **reduces nighttime awakenings**
- **sustains sleep 7 to 8 hours, on average, without repeating dosage**

REFERENCES: 1. Kales A, *et al*: *Arch Gen Psychiatry 23*:226-232, Sep 1970
2. Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington DC, May 3-7, 1971
3. Frost JD Jr: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
4. Vogel GW: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
5. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ

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Opinion & Dialogue

Is there a need for a drug compendium?

Government Health Official

Henry E. Simmons, M.D.
Deputy Assistant Secretary for Health
Department of Health, Education and Welfare

A drug compenc of the type I envis would fill a definite need for the pra ing physician. Su compendium w give him all information n essary for u a drug intelligently, and it woul do so in a clear, concise, convenient, objective and balance fashion.

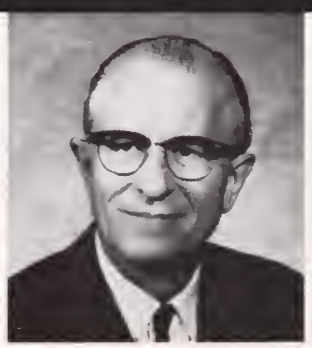
What a Compendium Should Contain

I believe the compendium should inform the doctor what drug will do, when he should us for what type of patient, for hov long, in what dose, what benefi his patient is likely to obtain, th risks involved, and cross-reacti with other drugs.

The information would be based on the package insert an have the same legal status. In fa a complete compendium with c plete and current information might even eliminate the neces

Maker of Medicine

Joseph F. Sadusk, Jr., M.D.
Warner-Lambert Company



A drug compendium, or preferably compendia, should, believe, be private, not federal, sponsorship. They should conta comprehensive listings of drugs available for prescribing. They should be single, legibly printe volumes of reasonable size, updated quarterly or semiannually and completely revised every ye

Function of a Compendium

A compendium should fur nish the following information o drugs in the following order: ind tions for use, side effects, adver drug reactions, contraindicatior, drug interactions, drug dosage the dosage forms marketed. Dr prices should not be included b cause they vary so widely and change rapidly.

No compendium should se forth drugs of choice or discuss relative efficacy. Such question must be left for the practicing p sician to decide, whether on the basis of the medical literature, h own clinical experience, advice colleagues, information supplie by manufacturers, and so on.

Nor should a compendium undertake to educate the doctor how to use drugs. Rather, it mus be a reference source designed marily to refresh his memory as drugs he may not use regularly.

a package insert in many in-
ices. This would constitute a
stantial saving for the manu-
urer.

By a complete compendium,
not mean a volume of prohibi-
size. You don't need a book
cribing 25,000 products with
enormous amount of repetition.
her, drugs should be arranged
class. Mutually applicable infor-
tion would be provided, along
brief discussions pinpointing
erences in specific drugs of
t class. Listings would be cross-
exed in a useful way.

er Available Documents as
rces of Information

Existing references such as
R and the AMA Drug Evaluation
obviously useful but they are
omplete. Either they are not
ss-referenced by generic name
I do not group drugs with simi-
characteristics, or they do not
all the available and legally
rketed drugs. And some of
se omitted may be very useful.

On the other hand, drugs made by more than one supplier, tetracycline for example, may be fully described a dozen times in the same book.

While perhaps PDR could be rearranged and cross-indexed with generics included, and while the AMA Drug Evaluation might also be modified and expanded, I am not sure that the end result would have all the attributes required for a useful compendium. At the same time, you would run the risk of amassing a voluminous and unwieldy tome.

Should Editorial Comments Accompany the Listings?

Subjective judgments, in my opinion, have no place in a compendium. However, if there is substantial evidence based on a sound body of science concerning relative efficacy of several drugs, certainly that information should be included. The committee of experts compiling and editing a particular section would also have to assess and indicate instances where a meaningful difference between drugs is pertinent.

Sponsorship, Compilation and Editing

Producing a book like this would undoubtedly be difficult and demanding. It would obviously take a great deal of talent and expertise, and would require a varied and experienced group, ranging from writers and editors to highly skilled clinicians and pharmacologists. Style, format and clarity of language would play an important part in determining the usefulness of the book. And it should be updated periodically and completely revised annually.

I have no opinion whether the government or the private sector should sponsor and/or finance the compendium. What is most important is that the compendium be an authoritative, objective and useful source of information for the doctor to have at hand as a ready reference.

---

uld in no way imply control over
practitioner's prerogatives.

y Another Compendium?

A practicable, single-volume
mpendium cannot, nor is it
cessary to, include all drugs on
market today. From my prac-
e of internal medicine for some
years, my experience as a con-
tant, and as a faculty member
four or five medical schools, I
uld estimate that a doctor uses
ly 30 to 35 drugs regularly. The
72 Physicians' Desk Reference,
cidentally, contained about
500 entries.

As to whether there should be
ederal compendium, in my opin-
, as stated earlier, the answer is
sy—there should *not* be one. The
oposal assumes that existing
mpendia are inadequate. We're
t sure of that at all. Whatever its
perfections, the present drug
ormation system in the U.S. is
en, multifaceted, pluralistic and
tensive. Good compendia exist,
well as other ample sources on
ug therapy, ranging from journal
erature through AMA Drug Evalu-
on to company materials. Not
physicians may use such
urces as often or as well as they
ould, but that is the fault of the
an, not of the sources.

In any event, rather than produce another book, it makes much more sense to work on improving existing compendia, and perhaps they could, as knowledge advances, include more accumulated clinical data and experience, and more information on drug interactions and adverse reactions.

Implications of a Federal Compendium

Take a hard look at the implications of a federal compendium. It would have the force of law, virtually dictating what drugs to use and how to use them. In effect, it would be a regulatory document with legal or quasi-legal status, posing medical/legal problems similar to those the doctor may now encounter if and when he departs from the provisions of the package insert. A compendium under federal aegis would tend to restrict decisions on drug therapy to one orthodox level—a most dangerous trend for medicine.

New Compendium—A Medical Option

I detect no ground swell of initiative or support whatsoever for a federal compendium—or, for that matter, for a new compendium of any type. A 1969 PMA survey conducted by Opinion Research Corporation found that only 15 per cent of those physicians interviewed felt a new compendium was needed. And a large majority did not favor the involvement of the federal government if one were to be created, preferring instead a nongovernmental consortium.

Even if we come to a time when the medical profession itself opts for a new kind of compendium, it should be handled and financed, ideally, outside both government and industry. Final review and editorial authority could be delegated, say, to specialty bodies and medical societies—but above all, *not* the government.

Surely the health care system in the United States has far more vital matters to consider than the extensive cost and effort that would have to go into the preparation and maintenance of a new, monolithic compendium, and especially one bearing the imprimatur of the federal government.

Opinion & Dialogue

What is your opinion, doctor? We would welcome your comments.

The Pharmaceutical
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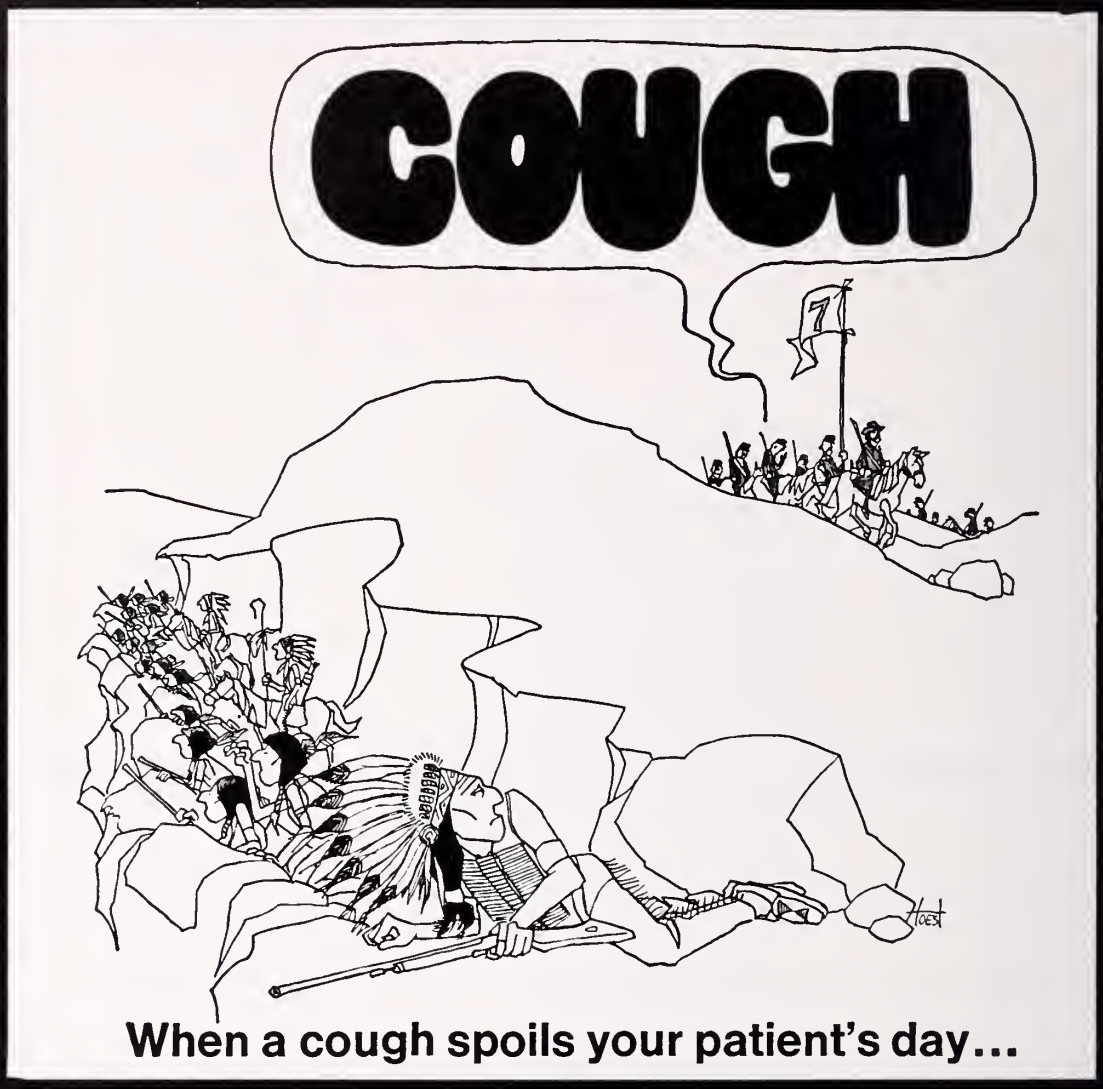

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Precautions: Exercise caution in: moderate to severe hepatic disease; anticoagulant therapy, because of possible increased metabolism of coumarin anticoagulants; withdrawal in drug dependence or the taking of excessive doses over a long period, to avoid withdrawal symptoms; elderly or debilitated patients, to avoid possible marked excitement or depression; use with alcohol or other CNS depressants, because of combined effects.
Adverse Reactions: Slight hangover, drowsiness, lethargy, headache, skin eruptions, nausea and vomiting, hypersensitivity reactions (especially in those with asthma, urticaria, angioneurotic edema, or similar conditions).
Usual Adult Dosage: For daytime sedation, 15 mg. to 30 mg. t.i.d. or q.i.d. For hypnosis, 50 mg. to 100 mg.
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PRESCRIBING INFORMATION

Antiminth (pyrantel pamoate) Oral Suspension

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13μg/ml.) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 cc.)

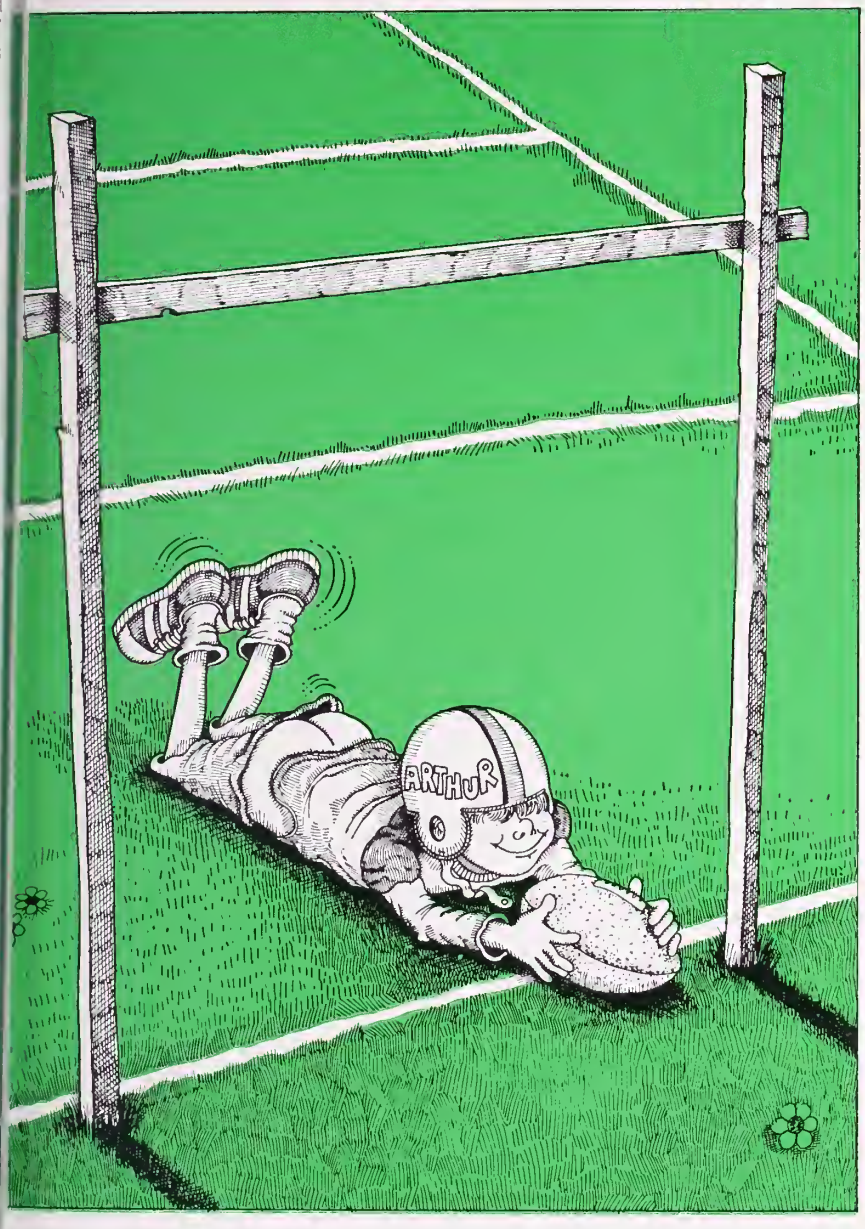
Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day; and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices. Because of limited data on repeated doses, no recommendations can be made.

How Supplied. Antiminth is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg. pyrantel base per ml., supplied in 60 cc. bottles.

ROERIG Pfizer

A division of Pfizer Pharmaceuticals
New York, New York 10017

WORMS BLITZED



A single dose of Antiminth (1 cc. per 10 lbs. of body weight, 1 tsp./50 lbs.—maximum dose, 4 tsp.=20 cc.) offers highly effective control of *both* pinworms and roundworms.

Antiminth has been shown to be extremely well tolerated by children and adults alike in clinical studies.* Pleasantly caramel-flavored, it is non-staining to teeth and oral mucosa on ingestion... doesn't stain stools, linen or clothing.

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Ampoules, equivalent to 1 Gm. of cefazolin

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The West Virginia Medical Journal

Vol. 70, No. 6 June, 1974

Cytoxan Therapy In The Treatment Of Carcinoma Of The Lung

(Report Of A Five-Year Survival)

Leonidas Castro, M. D.

It is well known that carcinoma of the lung is one of the leading causes of male cancer deaths. A recent report of the American Cancer Society estimates 79,000 new cases this year, an increase of approximately 3,000 cases over 1972. The incidence of lung carcinoma is increasing at an alarming rate. It is approximately 10 times more frequent in males than females and 15 times greater than 40 years ago. Fifty per cent of the patients presenting with bronchogenic carcinoma are inoperable when first seen. Half of those tumors amenable to surgery are unresectable. For this reason, it has been said: "Carcinoma of the lung is a fatal disease and truly early pulmonary cancers are a rare clinical entity."

The highest incidence of lung carcinoma is between the ages of 50 to 60 years. Less than one per cent occur below 30; approximately ten per cent after age 70.

The purpose of this report is to present the unusual case of a 24-year-old male with carcinoma of the lung who has survived five years after developing bone metastases. He was treated with radiation and Cyclophosphamide.

Case Report

In August 1966, R.R., a 24-year-old truck driver was seen in consultation at another institution with the complaints of chronic cough and tiredness for the last six weeks. The patient had been treated for pneumonia for two weeks without improvement. He had lost 12 pounds in five weeks.

On physical examination, the patient was not in acute distress, but had a productive cough with whitish sputum but no blood. On auscultation there was diminution of breath sounds on the right side and dullness to percussion. A chest x-ray on September 1, 1966 showed atelectasis and probable pneumonia in the right lung (Figure 1).

The Author

- **Leonidas Castro, M. D., Director, Radiotherapy Department, Ohio Valley Medical Center, Wheeling, West Virginia.**

On September 2, 1966, however, bronchoscopy showed a tumor mass filling the right mainstem bronchus at the level of the middle lobe orifice. Biopsy specimen was taken with some bleeding. The impression was bronchial adenoma or bronchogenic carcinoma. Cytology of bronchial washings was Class V. The bronchial biopsy showed undifferentiated carcinoma, probably of bronchial origin.

On September 8, 1966, a right thoracotomy was performed. A large tumor was biopsied. Histology revealed a malignant tumor characterized by numerous giant cells and abundant mitotic figures. The cells contained vacuolated eosinophilic cytoplasm and prominent red nucleoli. There was a heavy fibroblastic reaction to the presence of the tumor. Diagnosis was undifferentiated carcinoma (Figures 2, 3).

Because of some doubt as to whether this was truly undifferentiated carcinoma or sarcoma, the slides were sent to the Armed Forces Institute of Pathology in Washington, D. C. The final review came back as "pleomorphic bronchogenic carcinoma with metastases to the mediastinum."

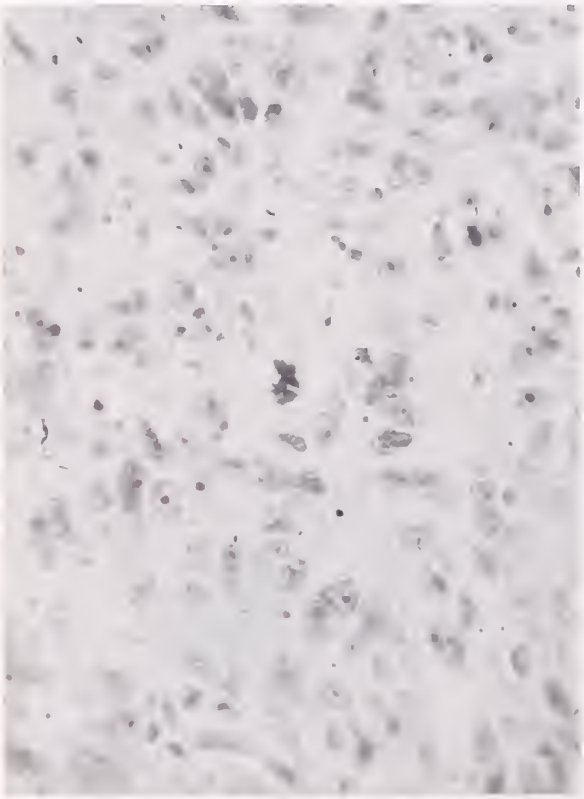
The patient was referred for radiation ther-

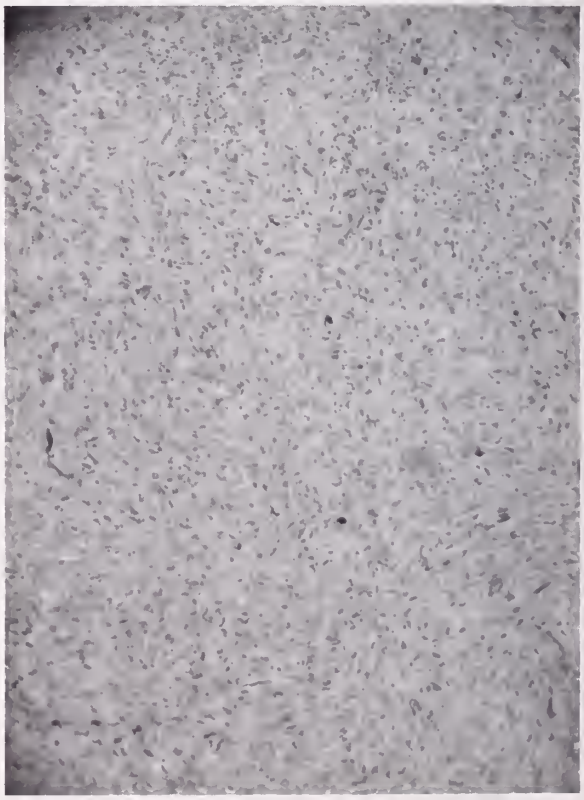
Figure 1. Bronchoscopy one day after this film showed a tumor mass filling the right main stem bronchus at the level of the middle lobe orifice. These is atelectasis and probably pneumonia.

apy. He was treated with a 25 MEV Betatron through opposing fields of 21 x 14 cm. covering the right lung. Between September 29, 1966 and November 11, 1966, he received a total tumor dose of 6000r. The patient obtained a good symptomatic response. Five months later a chest x-ray showed good resolution of the tumor mass (Figure 4).

In March 1967, he was admitted to the same institution following an accident at work. While climbing into a truck, he experienced severe pain in the left thigh. X-ray of the left thigh revealed a destructive lesion of the mid-shaft of the left femur at the location of the patient's pain and swelling. The patient had an open biopsy revealing a definite metastatic bone lesion. The histology of this tumor was essentially the same as the right lung tumor (Figures 5-6). The patient was discharged on crutches with plans for palliative radiation therapy.

In April 1967, the patient was referred to us in consultation for radiation therapy to the metastatic lesion of the left femur. The patient was walking with crutches and was in fairly good condition. The biopsy scar was well healed. Bone survey showed that the patient had questionable lytic metastases in the skull, distal femurs, right tibia and sacrum. The patient was started on a course of palliative Cobalt 60 Tele-





Figures 2-3. Abundant mitotic figures with large polyhedral cells giving a pleomorphic pattern. (High-Dry magnification). (Low power 1 x 100).

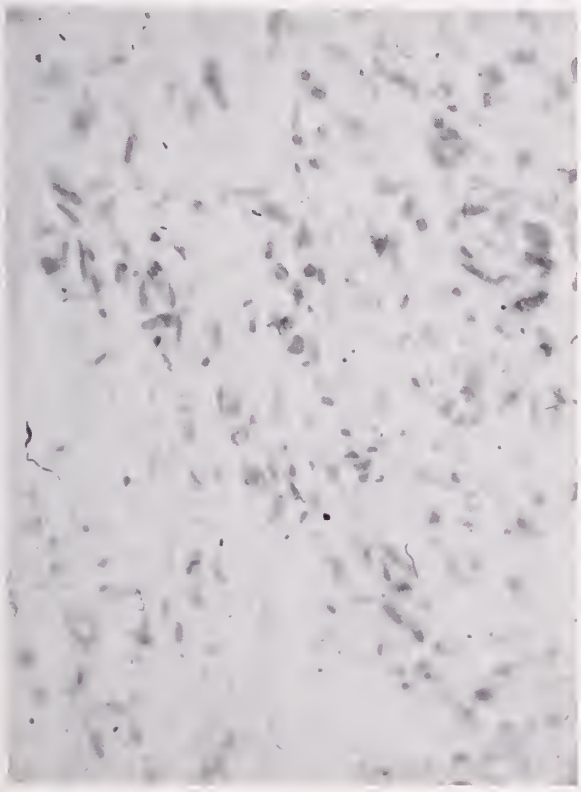
Figure 4. Five months after 6000r. delivered in six weeks with a 25 MEV Betatron, the tumor showing good resolution. There is some volume loss in the right lung, but overall improvement is present (4-27-67).

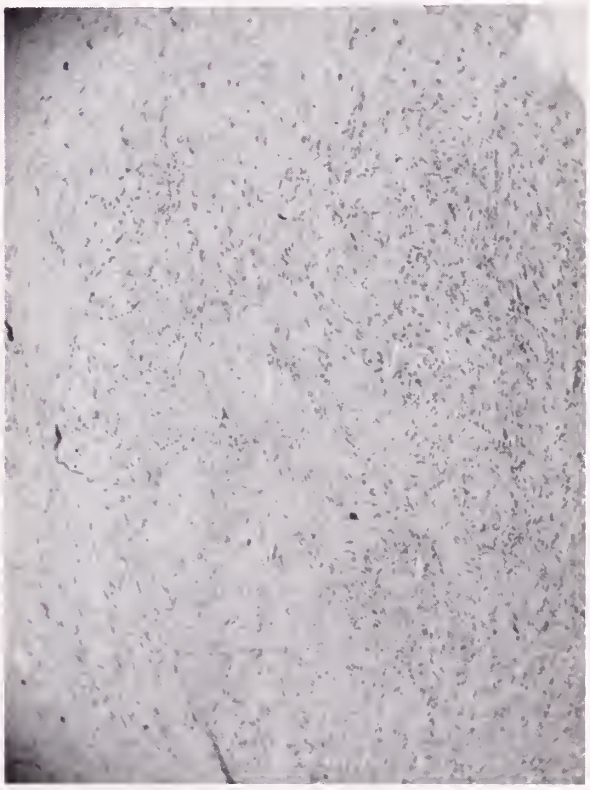
therapy to the left femur through opposing fields of 12 x 16 cm. Between May 1, 1967 to May 18, 1967, he received a total tumor dose of 3000r (Figure 7). Because of generalized bone metastases and the histology of the tumor, Cytoxan therapy was instituted. Scattered instances in the literature of up to 50 per cent initial response with good symptomatic relief in bronchogenic carcinoma were reported. Cyclophosphamide 50 mg. t.i.d. was started. At that time, the patient was also complaining of increased pain in the right femur. X-rays revealed a definite lytic lesion of the right femur with cortical destruction (Figure 8).

A palliative course of Cobalt 60 Teletherapy to the right femur was delivered through a single field of 10 x 15 cm. He received a tumor dose of 2000r in 12 treatments delivered over a 12-day interval. The patient had a good symptomatic response and was sent home to continue on Cytoxan 150 mg. daily.

Since then, the patient has been seen in our clinic in follow-up. Repeated bone surveys, SMA-12 surveys, chest x-rays and physical examinations have failed to reveal further evidence of recurrent or metastatic disease (Figure 9).

The last follow-up on this patient was on September 5, 1973. At that time he was feeling fine. His only complaint was shortness of breath





Figures 5-6. Metastatic lesion left femur, showing a similar pattern as in the primary lung tumor. (High-Low magnification).

Figure 7. On the right: Metastatic lesion on the left femur, treated with Cobalt 60, Teletherapy, T.D. 3000r in 18 days (5-18-67). On the left: Same area showing marked cortical thickening 5 years post-x-ray therapy and Cytoxan (5-22-72).

which he has had for some time, evidently due to the fibrotic radiation changes in the right lung.

In December 1971, or four and one-half years after Cytoxan 150 mg. t.i.d. was begun, the dose was reduced to 100 mg. daily. The dose has been reduced to 50 mg. daily during the past few months. The patient is working on his farm. The physical, radiologic and laboratory examinations of the last follow-up, six years and two months after starting on Cytoxan, were essentially normal. Cytoxan has been presently reduced to 50 mg. every other day. There has been no evidence of any toxicity from the Cytoxan therapy over this long period of time.

Discussion

Multiple chemotherapeutic agents have been tried in the treatment of advanced or inoperable carcinoma of the lung with very poor results. Cyclophosphamide has been one of the most promising agents in the attack of this dreadful tumor.

Reports from the British literature in 1965 show 50 per cent response obtained in 49 cases of bronchogenic carcinoma. Recent reports from the VA lung group who started a clinical trial in August 1962 state that for oat cell carcinoma, the use of Cyclophosphamide has given a definite increase in survival. Patients treated live almost three times longer than the placebo groups. Patients with squamous cell carcinoma or adenocarcinoma show no response. Also, patients with anaplastic and poorly differentiated carcinomas benefit with Cyclophosphamide while the use of Mechlorethamine is superior in squamous cell carcinoma and ineffective in adenocarcinoma.

The authors suggest that there is a selective activity on the histological group by the bifunctional alkalating agents. Objective response has also been noted with 1,3-BIS(2-Chloroethyl) 1-Nitrosourea (BCNU) but without increase in clinical survival. Hydroxy Urea has also given significant improvement in survival in extensive disease. Twenty per cent survive eight months against six months with a placebo.

The VA study group also states that Mechlorethamine, Cyclophosphamide and Methotrexate lead the list with objective responses in approximately 25 per cent to 35 per cent of cases with carcinoma of the lung. A recent report suggests that perhaps a combination of Vincristine, Prednisone, Cytoxan and Procarbazine gives quite significant improvement in oat cell carcinoma.

Figure 8. Faintly outlined metastatic lesion on the right, in the right femur. Left: Cortical thickening of the previous lesion 4 years after receiving 2000r. in 15 days with Cobalt 60 Teletherapy and Cytoxan.

Figure 9. Post-radiation changes are noted on the right six and one-half years after therapy. (Right rib fractures were due to interval trauma) (3-7-73).

Our case presented a very unusual patient of 24 years with pleomorphic bronchogenic carcinoma, extensive bone metastases and his very successful response to Cyclophosphamide alone for a "cure" of over six years. Statistical reports of five-year survival with extensive disease in carcinoma of the lung are very scanty and practically unknown. We feel, however, that chemotherapeutic agents such as Cyclophosphamide, Hydroxy Urea, BCNU, Methotrexate and others merit continued efforts as a "sometimes last resort" in the treatment of this "epidemic neoplasm."

There are still some questions in regard to the prolonged use of chemotherapeutic agents concerning immunologic aspects and response of these patients treated over long periods of time. Questions such as the extent Cyclophosphamide interferes with expression of established delayed hypersensitivity, newly induced delayed hypersensitivity and the ability to produce humoral antibodies to a foreign antigenic stimulus are still without definite answer. The direct correlation of favorable clinic response and immune suppression is still not well known. Previous studies, however, have shown definite benefit with the use of Cytoxan in certain cases of carcinoma of the lung, particularly oat cell and undifferentiated types. At least two studies mentioned in this paper agree statistically that the objective response has been in the neighborhood of 40 to 50 per cent. Nevertheless, as the initial response of the majority of patients has been short-lasting, further trials with new chemotherapeutic agents are being conducted. We hope that in the near future, responses such as the one we had with this exceptional case will be long-lasting.

Summary

This paper presents a six-year "cure" of a 24-year-old male with pleomorphic bronchogenic carcinoma and bone metastases treated with radiation therapy and Cyclophosphamide. There is no evidence of recurrent or metastatic disease. No toxic effects from Cyclophosphamide have occurred in spite of the long period of time that the patient has been on this agent.

Acknowledgment

The author wishes to express his gratitude to Dr. R. Kenneth Loeffler for providing the details of the primary treatment and Aultman Hospital, Canton, Ohio for sending the slides.

A list of references may be obtained by writing The Journal.

Medical Grand Rounds

From the West Virginia University Medical Center

Edited By

Raymond B. Weiss, M. D.

Assistant Professor of Medicine

(Three Case Presentations)

(1) Superior Vena Cava (SVC) Obstruction Syndrome

James Doll, M. D., Resident in Medicine, West Virginia University Hospital.

(Case History)

THE patient is a 52-year-old coal miner admitted to this hospital for the first time in December 1973 for evaluation of a possible superior vena cava obstruction. He was in good health until July 1973, when he noticed dryness of his mouth. In September he noted weakness of his thighs and hands to the extent that he could not tear paper or rise from a chair without aid. These symptoms had almost completely abated with his admission to this hospital except for some minimal thigh weakness. In December early morning periorbital and facial edema were noted. He complained of neck fullness, and exercise of any type caused dyspnea with a full feeling of his chest, neck, and head. He also noted that bending forward caused his face to feel full and flushed. His voice was deeper but not hoarse. He had a cough for three weeks productive of yellow mucus but without hemoptysis. He had a 35-pack-year history of smoking and had lost thirty pounds since July, although this loss was partially due to a voluntary diet. The remainder of his history was unremarkable.

Physical examination revealed distention of the neck veins to the angle of the mandible at 90°. The neck veins didn't vary with respiration, and there was marked fullness of his neck. There were decreased breath sounds in both upper lungs posteriorly. In the supine position cyanosis of his head, neck, and upper chest with visible collateral veins on his upper chest were noted. He had weakness of his thighs demonstrated by inability to hop and difficulty squatting.

Laboratory tests including blood counts and serum chemistries were within normal limits. Bronchoscopy, scalene node biopsy, and mediastinoscopy were not diagnostic. Chest x-ray (Figure 1) showed a prominent right hilum and superior vena cava with irregular oval infiltrates in the right upper lobe and right lower lobe. A selective view of a superior vena cavagram (Figure 2) showed complete obstruction of the superior vena cava with tumor invading the lumen. Thoracotomy revealed small cell undifferentiated carcinoma of the lung invading the mediastrinum.

Discussion

The Superior Vena Cava Syndrome was first described by William Hunter in "Medical Observations and Inquiries," in 1757, in which a case due to aortic aneurysm was described.

Diagnosis of the acute syndrome is rarely a problem, but the etiology is sometimes more difficult to establish. From reviews of the literature during the period 1904-1954, the frequency of primary thoracic neoplasms as the cause of the SVC syndrome was relatively constant, ranging from 35-51 per cent. In recent years, however, bronchogenic carcinoma has accounted for approximately 80 per cent of the cases and other intrathoracic tumors account for another 10 per cent. It is anticipated that two to five thousand new cases of this syndrome may present each year in this country.

An etiologic classification by Lowenberg et al[1] includes:

(1) Carcinoma of the lung — primary or metastatic.

(2) Mediastinal Lesions:

Figure 1 (left). PA chest x-ray showing abnormal right hilum and right upper lobe. Figure 2 (right). Vena cavagram showing filling defect from tumor invasion (arrows).

A. Lymphomas, leukemia, neurogenic tumors.

B. Thymoma.

C. Tuberculosis or syphilitic mediastinitis.

D. Histoplasmosis mediastinitis.

E. Nonspecific or idiopathic chronic fibrosing mediastinitis.

F. Post-irradiation mediastinal fibrosis.

G. Mediastinal trauma with hematoma formation.

H. Benign mediastinal tumors: substernal goiter, dermoid cysts.

(3) Idiopathic thrombosis of the superior vena cava.

(4) Aneurysm of the ascending aorta.

(5) A-V fistula between the ascending aorta and the superior vena cava.

Symptoms and signs are related to rapidity of onset, completeness of obstruction, venous hypertension cephalad to the lesion, and to the pressure effects of the mediastinal lesion itself. These include: dilatation of collateral superficial veins of the neck, arms, chest, and esophagus; edema of the face, neck, and upper extremities; flushing or cyanosis; central nervous symptoms such as headache, nausea, dizziness, distortion of vision, drowsiness, stupor and even convulsions; and prominence of the eyes with injection of the conjunctiva. All symptoms are intensified by recumbency, and cyanosis may be intensified by instructing the patient to lean forward for several minutes.

Diagnosis is usually made clinically but, if the diagnosis is in doubt and specific etology is sought, other methods employed are:

(1) Antecubital venous pressure readings.

(2) Venography and intravenous angiocardiography.

(3) Bronchoscopy, mediastinoscopy, and lung biopsy.

(4) Tomograms.

(5) Scalene node biopsy.

(6) Thoracotomy.

Of 61 cases reported by Urschel and Paulson[2] a clinical diagnosis was made in thirty; bronchoscopy and scalene node biopsy yielded a diagnosis in eleven cases each, mediastinoscopy in five, and thoracotomy in four. Fifty-five of the lesions were malignant.

Treatment of the SVC syndrome is primarily radiation. Subjective improvement of symptoms usually occurs 24-72 hours after initiation of therapy if the patient has a radiosensitive tumor. Objective improvement may be delayed but usually is evident by the 10th day of treatment. Diuretics may be used initially to decrease edema and steroids have been employed to decrease so-called "radiation edema."

Surgery and chemotherapy are infrequently utilized in the treatment of the SVC syndrome.

Surgery may be employed when there is a benign lesion causing obstruction such as a thymoma or retrosternal goiter. Chemotherapy may be employed for those patients who can't have radiation and for those patients with lymphomas in adjunct to radiation. Levitt et al,[3] in a randomized study, compared the treatment of malignant SVC syndrome between patients treated with radiation alone and those treated with radiation and nitrogen mustard. He found there was no apparent advantage to the additional use of nitrogen mustard.

Prognosis is generally poor because 80-90 per cent of the patients have bronchogenic carcinoma. The SVC syndrome may present as a medical emergency manifested by respiratory, cardiovascular, or CNS insult. Radiation frequently needs to be administered immediately even before a tissue diagnosis is sought. Of the 61 patients reviewed by Urshel the average survival after the onset of symptoms was seven months in the malignant group. Of 31 patients treated with 4000 rads by Longacre and Shockman[4] the median survival was six months. These latter authors speculate that the survival may be shortened by cardiac involvement which they found in 70 per cent of their cases. They felt that survival may be lengthened if radiation is extended to include a portion of the heart.

In summary the SVC syndrome is not an uncommon clinical entity. Recognition by physicians is of utmost importance because it occasionally constitutes a medical emergency.

Edmund B. Flink, M. D., Professor and Chairman, Department of Medicine.

The body doesn't tolerate very high pressure in the superior vena cava. Patients with superior vena cava obstruction usually do not have orthopnea so they are able to lie flat. Thus, edema of the face, pharynx and larynx result. I would like to emphasize that the very simple maneuver of having the patient sleep with his head and trunk of his body raised at least to 30° from the horizontal will ameliorate or eliminate the troublesome laryngeal and pharyngeal edema.

W. K. C. Morgan, M. D., Professor of Medicine, Division of Pulmonary Disease.

I note that this patient underwent a scalene node biopsy. As a general rule this procedure should be avoided in superior vena cava obstruction since it frequently leads to troublesome and indeed life-threatening hemorrhage. An additional point that needs to be made concerns the fact that superior vena cava obstruction these days is nearly always produced by lung cancer. The tumor is usually located in the apical segmental bronchus and is often impossible to see with a standard rigid Jackson bronchoscope. The fiberoptic bronchoscope has greater potential in this regard. Nonetheless, when a subject has superior vena cava obstruction, provided the history, signs, and chest film suggest that lung cancer is responsible, most radiotherapists are willing to undertake therapy in the absence of a tissue diagnosis.

Figure 3. Chest x-ray from patient with asbestosis showing interstitial infiltrate in left lower lobe.

(2) Subacute Thyroiditis

Myron Knell, M. D., Resident in Medicine, West Virginia University Hospital.

(Case Presentation)

The patient is a 43-year-old female who was well until August 1973 when she noted easy fatigability. Her family physician diagnosed hypothyroidism and prescribed daily Synthroid. She apparently did well until early October when she had malaise, fatigue, nightly fever and chills, painful swallowing, and neck fullness with pain radiating to her jaws and ears. She lost six to seven pounds over the month prior to admission and was taking antibiotics without relief of symptoms. Her past medical history was negative.

Physical exam showed a blood pressure of 90/70, pulse 92, and a temperature of 37°C.

Positive findings included a diffusely enlarged, firm, tender thyroid. The right lobe measured five and one-half by three cm. and the left lobe four by three cm. No bruits were heard. A tender lymph node was palpated in the left supraclavicular fossa. She had no signs of either hyper-or hypothyroidism.

Pertinent laboratory studies included a normal WBC and differential, a mild normocytic — normochromic anemia, a cholesterol of 105, two T^4 determinations of greater than 20 mcg per cent, extremely poor uptake on technetium thyroid scan, T^3 trisorb test of 42.3 per cent, and negative blood cultures.

During hospitalization she continued to have pain and afternoon temperature spikes in spite of aspirin therapy. After starting Prednisone 40 mg. daily, she had dramatic reversal of her symptoms and became afebrile. On follow-up in the clinic three weeks after discharge, she was doing well with a T^4 of 6.3 and an ESR of 34.

Discussion

Subacute thyroiditis, known under various names including de Quervain's, giant cell, pseudogiant cell, tuberculous, pseudotuberculous, granulomatous, sclerosing, and acute non-suppurative thyroiditis, is an uncommon disease estimated to be one-eighth as frequent as hyperthyroidism and one-tenth as common as Hashimoto's thyroiditis. It affects primarily young and middle-aged women with the average age of onset between 40 and 50 years and women to men ratio of about five to one.

The etiology of subacute thyroiditis remains obscure but the most popular theory now implicates a viral infection, because there is often a preceding URI or viral-like prodrome. The condition may occur at the time of a specific viral epidemic, and complete recovery is the rule. Auto-immunity has seriously been considered but thyroid antibodies appear in only 40-50 per cent of patients, usually several weeks after the onset of the disease, and titers remain low or moderate and are generally transient.

The clinical manifestations vary considerably in severity and mode of onset from the acutely ill to the asymptomatic patient. Local symptoms characteristically involve moderate to severe pain over one or both lobes of the thyroid which often radiates to the mandibular angle and ear on the involved side or sides. There may be a sensation of a tender lump in the throat and coughing or swallowing may aggravate the pain. Most people have systemic symptoms including malaise, fatigue, and mild fever but fever may occasionally reach 103° to 104°. If patients present early in the course, symptoms and signs of hyperthyroidism are usually present. The physical exam shows slight to moderate thyroid enlargement with marked tenderness and very firm to hard consistency of the affected lobes. Cervical lymphadenopathy does not occur.

The course of the disease is divided into four stages:

(1) The first is the thyrotoxic phase lasting from one to two months. It is characterized by acute illness and thyrotoxic symptoms with destruction of the gland pouring out iodinated materials into the circulation thus causing an elevation of PBI out of proportion to an increased T^4. The I^{131} uptake is markedly depressed, and ESR markedly increased, often greater than 100.

(2) Stage II is the transition or euthyroid phase lasting one to three weeks in which the gland is much less tender but still large and hard. The PBI returns to normal but the I^{131} uptake is still low, and ESR still elevated. At this point the mild to moderately ill patient may not progress but recover normal thyroid function.

(3) Stage III is the hypothyroid phase lasting from two to seven months in which the patient often becomes myxedematous. Now the I^{131} uptake increases but the PBI is variable.

(4) Stage IV is the recovery or remission phase requiring one to six months in which clinical and lab parameters return to normal. Most patients do recover entirely but permanent myxedema can occur. Relapses causing prolonged illness are found in a significant number of cases.

Other lab findings include a normal total WBC count and differential, normal serum cholesterol, a normochromic anemia of the chronic infection type in approximately 20 per cent of patients, and frequently decreased serum albumin and elevated serum globulin levels. As mentioned before thyroid antibodies appear in less than one-half of patients, are usually low in titer and transient.

Perhaps the hardest differential diagnosis is Hashimoto's thyroiditis since it can present with identical clinical and lab findings. In this disease, however, the T^4 is usually subnormal, the I^{131} uptake is rarely so depressed, thyroid antibodies persist, and permanent hypothyroidism results in about one-half the patients.

Therapy is directed towards controlling the symptoms as the disease process is not altered. In mild cases aspirin is usually effective, but in severe cases, corticosteroids give the best results. Steroids, however, tend to reduce the I^{131} uptake and PBI levels but not to affect antibody formation. Thyroid hormone preparations should be added to control the myxedema of Stage III or in the event of an exacerbation.

Paul E. Steffes, M. D., Assistant Professor of Medicine, Division of Endocrinology.

There are three interesting aspects to this patient's disease. Perhaps the most interesting is that she had sought a physician's advice some two to three months before the onset of the acute syndrome for symptoms which were reminiscent of but not specific for hypothyroidism. A blood test (which we were unfortunately unable to retrieve) was taken, a diagnosis of hypothyroidism was suggested, and the woman was started on Synthroid 0.1 mg. daily. It is possible that the vague symptom complex at that time was merely a prodrome of the acute episode to come. A serum test, however, of thyroid function—probably PBI or serum thyroxine—was evidently low, and thus it is also possible that the acute episode prompting her referral here was actually an exacerbation of an initially asymptomatic thyroiditis, first coming to medical attention during the hypothyroid phase (Stage III described by Doctor Knell). Exacerbations are not uncommon, and asymptomatic subacute thyroiditis accounts for as much as 50 per cent of the thyroid cases going to surgery.

Another point is that a recurrence occurred despite thyroid replacement. It has been suggested that thyroid suppression combined with salicylates is adequate treatment. This case is one example of an obvious failure of thyroid suppression in preventing either the initial or a recurrent episode of acute thyroiditis.

The third point is that the initial conservative approach to management consisting of 10 grains of aspirin every four hours was clearly a failure in relieving this woman's fever and neck pain. However, when 40 mg. of prednisone as a single morning dose was started, within 24 hours there was relief of malaise and fever, increase in well-being, and total disappearance within three days of anterior neck pain. This rapid defervescence seems to be characteristic of the response of subacute thyroiditis to steriod therapy. The literature notes very few steroid failures, although symptoms can recur during tapering of the dose and require reinstitution of full dosage.

Figure 4. Chest x-ray from patient with malignant mesothelioma showing left pleural mass (arrow) and pleural effusion.

Edmund B. Flink, M. D.

I wish to emphasize the fact that the iodine uptake is virtually zero in subacute thyroiditis while it is normal or even high in Hashimoto's thyroiditis. The thyroxin level is higher than normal in subacute thyroiditis but is low or normal in Hashimoto's thyroiditis. These findings are diametrically opposite and, in a sense, they are paradoxical and can cause confusion. The sedimentation rate usually is very high in subacute thyroiditis.

(3) Asbestosis

Patrick L. Brown, M. D., Resident in Medicine, West Virginia University Hospital.

We will next consider an environmental hazard which is ubiquitous in its distribution. Asbestos exposure has unequivocally been associated with interstitial pulmonary fibrosis and neoplasia. I would like to present three cases which are representative of the problems of asbestos exposure.

Case 1. A 55-year-old white male with a 50-pack-year smoking history who has had 11 years of occupational exposure to asbestos as a pipe fitter. His last exposure to asbestos was 10 years prior to admission. He denied any respiratory symptoms. Chest auscultation revealed bilateral basilar rales. Chest x-ray revealed a reticular-

nodular pattern compatible with pulmonary asbestosis. Pulmonary function tests were also compatible with early asbestosis. His observed FEV_1 was 1.98 L/min. (predicted 2.66 L/min.) and his observed FVC was 2.60 L. (predicted 4.24 L). FVC ratio observed to predicted was 61 per cent (normal greater than 80 per cent). FEV_1/FVC was 75 per cent which is within normal limits. The diffusing capacity was reduced and the airway resistance was within normal limits.

Case 2. A 58-year-old white male who presented with an eight-year history of progressive dyspnea on exertion and two to three pillow orthopnea. He had a chronic productive cough. He was a 40-pack-year smoker. He had a history of exposure to asbestos as a construction worker which extended up to 10 years prior to admission. Chest x-ray revealed pleural reaction and stringy interstitial fibrosis in the left lung field (Figure 3).

Case 3. A 33-year-old white female who presented with a 10-month history of weight loss, chest pain and dyspnea. She had a left pleural effusion which was bloody. Her husband had had definite occupational exposure to asbestos and she frequently handled his clothing. Chest x-ray revealed a pleural mass and left pleural effusion (Figure 4). Pathologic diagnosis was malignant mesothelioma.

Discussion

Asbestos is a mixture of silicates which occurs naturally in the form of fibers whose lengths range up to 30 cm. Very small particles of the size of 50 u by 0.5 u are the ones responsible for asbestosis. Asbestos is made by crushing rock to yield fibers and amorphous powder. The uses of asbestos are many and are expanding rapidly. They include such diverse products as fireproof clothing, brake and clutch linings, cement, insulation, paints, and tile. Asbestos has even been found in drinking water and beer.

There are four major types of asbestos — chrysotile, anthophyllite, amosite and crocidolite. The most important one in the United States is chrysotile which is magnesium silicate. Chrysotile is used much more than any other type of fiber in the United States. The second type is anthophyllite which is mined principally in Finland and is associated with pleural calcifications. The third type, amosite, has extremely long fibers — 30 cm. in length — and is not used frequently. Crocidolite, the fourth type, is mined principally in South Africa and is probably the most carcinogenic. It has been associated with mesothelioma in South Africa.

Because of the long size of the asbestos particles (50 u), the fibers are deposited mainly in the alveoli distal to the respiratory bronchioles in the lower lobes. Some people have questioned the possibility of such large particles reaching the alveoli, but the main parameter of particle entry into the pulmonary tissue is the diameter of the particle, not the length.

The asbestos fibers in the lung become covered with a proteinaceous material which is impregnated with hemosiderin, thus forming the characteristic asbestos body. This asbestos body is indicative of asbestos exposure, but not diagnostic of asbestosis. The asbestos fibers in the alveoli initially become enmeshed along with alveoler macrophages by reticulum fibers. This is the first lesion of asbestosis. This is then followed by intersititial fibrosis.

The actual reasons for this fibrosis are not known, although several theories have been postulated. The original theory was that the direct physical irritation of fibers led to fibrosis. Another theory is that caustic substances are released as the fiber dissolves and these cause fibrosis. A third theory is an auto-immune phenomenon. Others have postulated that the asbestos may have direct stimulatory effect on fibroblasts. A further theory is that the disintegrating phagocytes release sclerosing agents such as lipids or lipoproteins.

Pathologically, asbestosis is characterized by lower lobe lesions which are diffuse, gray fibrotic lesions. The pleura is thickened and there are often adhesions.

Pleural plaques occur generally bilaterally. They are usually small and only 15 per cent are detectable during life. The plaques occur mainly in lower lung areas and are laminated collagen which are variably calcified. Single plaques generally occur on the diaphragmatic pleura. Pleural calcification may occur without radiographic evidence of asbestosis. The development of pleural plaques is related to duration of asbestos exposure. The relationship between pleural plaques and mesotheliomas is not known as many people in Finland have pleural plaques but almost no cases of mesothelioma have been reported there.

In patients with asbestosis the course is generally protracted unless neoplasia intervenes. It is generally felt that a latent period of 10 years of asbestos exposure is required before asbestosis can be detected.[7]

Pulmonary fibrosis was not found in any non-smokers with less than 20 years' exposure, but in smokers with less than 20 years exposure the prevalence was 29 per cent. In non-smokers with greater than 20 years' exposure the prevalence was 43 per cent and the prevalence for smokers was 57 per cent. Therefore smoking increases the prevalence of fibrosis. Duration of asbestos exposure increases prevalence of fibrosis.[8]

Some symptoms of asbestosis are progressive dyspnea on exertion, cough which is initially non-productive but later becomes productive, weakness and weight loss. The classical physical finding is bilateral basilar rales. Also they can have clubbing and occasionally the signs of pleural effusion. Of course, these are very non-specific signs and symptoms and are not necessarily diagnostic of asbestosis.

In Guensler's[9] study of 91 pleural effusions 13 per cent were secondary to asbestos. Out of 57 patients with asbestosis in his series, 24 developed pleural effusions and 10 of these were secondary to malignancy. Twelve were secondary to asbestosis alone. The asbestos effusions were sterile, serous or blood-tinged exudates.

To make the diagnosis of asbestos - induced pleural effusion one must rule out other causes and document an exposure in the past to asbestos. Definitive diagnosis is by open biopsy. Needle biopsy of the pleura is not helpful in making the diagnosis because asbestos bodies are rarely found on pleural biopsy. Usually examination of the fluid for sugar, hyaluronic acid, and asbestos bodies or fibers is fruitless. The pleura will generally show only non-specific changes.

The derangements of pulmonary function are characterized by restrictive ventilatory impairment, decreased compliance, and decreased diffusion capacity. The pulmonary function studies in our first case illustrate well these abnormalities. The FEV_1 and VC were markedly reduced. The diffusion capacity was reduced. The airway resistance was normal and FEV_1/VC ratio was 75 per cent which is within normal limits. The closing volume could not be determined which is consistent with restrictive lung disease.

The x-ray findings of asbestosis generally are in the lower lung fields and vary from a fine, mottled appearance to marked, streaky fibrosis which may appear to give the heart a shaggy border. Calcified plaques may be seen and if they are bilateral it is almost pathognomonic of asbestosis.

The diagnostic criteria of asbestosis used by Murphy[7] are that three of the following five findings must be present and asbestos exposure must be proven: (1) Dyspnea on climbing one flight of stairs. (2) Significant clubbing of fingers. (3) Vital capacity of less than 80 per cent predicted. (4) Basilar rales in two or more sites. (5) Chest x-ray consistent with moderate to advanced asbestosis.

Treatment is to remove the patient from exposure and treat the complications. Steroids have not been shown to be of much value. The cause of death is usually respiratory insufficiency, neoplasia, or TB.

Mesothelioma has unquestionably been linked to asbestos exposure and the exposure may be only minimal. In Borow's[10] review of 72 cases of mesothelioma, a history of exposure was found in all except 12 who had inadequate histories. Selikoff[11] has shown that cigarette smoking increases the chance of mesothelioma in people exposed to asbestos. The incidence of mesothelioma appears to be increasing. There is a latent period of 20-40 years after exposure to asbestos for development of mesothelioma. Patients with pleural mesothelioma generally present with either chest wall pain or pleural effusion or both. Patients who develop peritoneal mesotheliomas present with vague abdominal discomfort, ascites, or weight loss. Generally mesotheliomas do not invade or metastasize widely but kill by local pressure and restrictive effects. Median survival in mesothelioma is only about 15 months.

Selikoff and others have shown an increased incidence of bronchogenic carcinoma in patients with asbestosis compared with the general population. There is also the possibility that the incidence of gastrointestinal malignancy is increased in asbestos workers.

W. K. C. Morgan, M. D.

In his presentation Doctor Brown mentioned that the greater the exposure to asbestos, the more likely is the exposed person to develop a pleural plaque. This is a misleading statement since many subjects with pleural plaques have minimal exposure and have had only what is known as a "neighborhood exposure." This implies that they have inhaled asbestos fibers from general air pollution rather than from an occupational exposure. Thus, many of the pleural plaques that have been reported in Finnish subjects have been shown to be due to contamination of the ambient air by anthophyllite. Pleural plaques in Finland are, however, benign

and are seldom associated with mesothelioma. In this regard, the development of mesothelioma is directly related to the shape and "penetrability" of the asbestos fibers. If the fibers are sharp and pointed, they can migrate more easily to the pleural surface. Timbrell of the Pneumoconiosis Research Unit in Wales made this point several years ago and subsequent animal experiments have confirmed his observations.

A list of references may be obtained by writing The Journal.

Manuscript Information

Manuscripts to be presented for publication in *The West Virginia Medical Journal* should be typewritten, triple-spaced, on one side only of firm (not onion skin or flimsy), standard letter sized (8½ by 11 in.) white paper. Wide margins (at least 1¼ in. on left) should be left free of typing. On the first or title page should be shown the title of the article, the name (or names) of the author, and his degrees. Pages should be numbered consecutively, the page number being shown in the right upper corner along with the surname of the author.

Authors are requested to submit a carbon copy with the original or retain same in the event the manuscript is lost in transmittal.

Illustrations should be numbered and their approximate locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for cuts should be done in black (India) ink on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it. The author will bear the cost of all over two one-column halftone cuts.

All scientific material appearing in *The Journal* is reviewed by the Editorial Board. Manuscripts should be mailed to The Editor, West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

X-Ray Case of the Month

Acute Volvulus Of The Sigmoid Colon

Paul P. Williams, C. S. Krishna Murthy, M. D.; Mansour Djadalizadeh, M. D.; and Raymond C. Bonnabeau, Jr., M. D.

A 53-year-old, previously healthy white male was seen at the Clarksburg Veterans Administration Hospital after developing crampy lower abdominal pain 24 hours prior to admission. During this period, no stool or flatus had been passed. There had been no nausea or vomiting.

At physical examination, a distended, tympanic abdomen, painful to palpation primarily over both lower quadrants, was noted. Bowel sounds were hyperactive with frequent rushes. The white blood cell count was 10,600.

Roentgenographic Findings

Flat (Figure 1A) and upright abdominal x-rays revealed a grossly distended loop of colon arising from the left lower quadrant. There was no air in the rectum. The overall picture was consistent with that of a low lying colonic obstruction. A diagnostic barium enema (Figure 1B) revealed rectal filling distally with proximal tapering of the rectosigmoid to a blunted point. Diagnosis: Acute volvulus of the sigmoid colon.

Hospital Course

Although partial decompression of the obstruction occurred at the time of the barium enema, complete decompression was able to be accomplished immediately afterwards by means of sigmoidoscopy. A rectal tube was then left in place (proximal to the point at which the bowel had twisted) for 48 hours. Six days later, repeat barium enema (Figure 1C) revealed a markedly tortuous sigmoid colon. The patient underwent a successful elective sigmoid resection with reconstitution of bowel continuity by means of an end-to-end anastomosis six weeks later.

Comment

A volvulus may be defined as an abnormal twisting of a portion of the bowel upon itself along its longitudinal axis. This will result in

The Authors

- **Paul P. Williams, third-year medical student, West Virginia University School of Medicine, Morgantown; C. S. Krishna Murthy, M. D.; Mansour Djadalizadeh, M. D.; and Raymond C. Bonnabeau, Jr., M. D., all from the Veterans Administration Hospital, Clarksburg, West Virginia.**

Figure 1-A. Flat plate of the patient's abdomen done on admission. This revealed a grossly distended loop of colon arising from the left lower quadrant. Note the lack of air in the rectum. The picture is consistent with that of a low lying colonic obstruction. Figure 1-B. Diagnostic barium enema at the time of admission. This showed rectal filling distally and a proximal tapering of the rectosigmoid, diagnostic of an acute sigmoid volvulus. The actual point of twisting was demonstrated (arrow). Figure 1-C. Repeat barium enema six days after admission confirms the presence of a markedly tortuous sigmoid colon. This was resected successfully six weeks later as an elective procedure.

either partial or complete, and therefore a closed loop type of, intestinal obstruction. Unless decompression occurs, the end result of complete obstruction will be gangrene and perforation of the bowel wall with peritonitis.

Two anatomical conditions are necessary for volvulus development: (1) A redundant segment of bowel that is mobile and free in the abdominal cavity; (2) close approximation of both ends of the freely movable segment. When certain forces (such as the weight of the bowel content, the changing position of the individual, or the presence of a neoplasm) produce the right movements of this mobile segment, the result can be a twist of the closely approximated portions about each other.

In the United States, volvulus accounts for approximately four per cent of all colonic obstructions. Seventy-five to 85 per cent of these occur in the sigmoid colon, since this structure (so named because of its "S" shape) easily conforms to the two previously mentioned predisposing criteria.

Although a patient may present with a sigmoid volvulus as an initial event (as in the case outlined), it can also be recurrent in nature. Thus, a history of multiple bouts of intermittent, crampy, low abdominal pain, accompanied by abdominal distention, may be elicited. These episodes in the past will have resolved spontaneously with the passing of large amounts of gas and stool. Due to the recurrent nature of this entity, resection of the offending sigmoid, preferably done as an elective procedure after the acute episode has been resolved, as in the case presented, should be carried out.

Non-Tobacco Cigarets Hazardous to Health

Cigarets of dried lettuce or grass are just as damaging to the respiratory system as those of tobacco, says a report in the May issue of *Archives of Environmental Health*, a publications of the American Medical Association.

"Grass" in the research report is Kentucky bluestem, not marijuana.

A research pair at the University of Tennessee, Knoxville, used commercially prepared lettuce cigarets and cigarets which they made in the laboratory from grass in an effort to determine whether the non-tobacco products would be safe, or less harmful. They found that the adverse effect on the respiratory system's defense mechanism was just as bad for the non-tobacco cigarets as from the genuine article.

They concluded that smoke from any burnable material will cause respiratory damage. In one aspect of the study, they used purified nicotine to see whether it was involved in the respiratory damage. They found that it was the smoke, not the nicotine, that was at fault.

The study is by John P. Gray, M.S., and John R. Kennedy, Ph.D., of the University's department of zoology.

The President's Page

YOUR WIFE AND THE AUXILIARY

Mrs. J. Dennis Kugel, President
Woman's Auxiliary to the
West Virginia State Medical Association

Dear Doctor,

Have you ever really thought about the Auxiliary to your County Medical Society? Have you wondered if it is a worthwhile organization; if the time your wife spends in the meetings is really necessary; if all the volunteer work serves a real purpose?

When your wife joins "The Auxiliary" she becomes part of an organization that has as its goal the betterment of the doctor's "image" and advancement of medicine and public health. She joins with almost 100,000 other women who share the same sort of problems, and have much the same interests. Her voice is heard and she can help *you.*

But—unless she will join, how can she know the many areas in which she can help you?

But can you help us? Urge your wife to become a member of your county auxiliary. If you don't have an organized group, she can become a member-at-large. She will be welcomed with open arms and I know she will surely find at least one thing to capture her interest.

Last, but far from least, she will meet new faces and make lasting friendships.

With love from all of us,

Marjorie L. Kugel

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Editor
GEORGE F. EVANS, M. D.
122 South Sixth St.
Clarksburg, W. Va.

Managing Editor and
Business Manager
MR. WILLIAM H. LIVELY
Box 1031
Charleston, W. Va. 25324

Associate Editors:
VERNON E. DUCKWALL, M. D.
Elkins
JOHN M. HARTMAN, M. D.
Charleston
THOMAS J. HOLBROOK, M. D.
Huntington
JOE N. JARRETT, M. D.
Oak Hill
EDWARD J. VAN LIERE, M. D.
Morgantown
STEPHEN D. WARD, M. D.
Wheeling

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EDITORIALS

OUT OF THE PACK

Unanimity be damned! If every other publication in the country marches in lock-step to the beat of Watergate war drums, it is no reason for us to mindlessly join them. If other members of the fourth estate compete for favor and renown within their own ranks by their meretricious Watergate nit-picking, it should be no temptation for us to join such a hollow contest. If some must show the quality of their bravery by kicking and striking a grieviously wounded Administration already brought to its knees, it should be no occasion for us to join such vainglory.

We have been witnessing in the Watergate sensation, as much as anything, an orgy of self-adulation and self-inflation by editorialists convinced of their own heroic proportions. So inflated must be some by now, that their only release from editorial room ceilings is via a dangling string. The extent of this phenomenon makes one ponder the depths of newsgatherers' needs for appreciation and the emptiness of their callings prior to the salvation of Watergate. Is the Watergate expose really the grandest thing that a free press has ever done for its eager readers?

Whatever lesson there was to be learned by the participants in the various Watergate illegalities has long since been learned. The further pursuit of these matters has for some time now shown all of the hallmarks of a vicious and vengeful vendetta carried on for reasons which are at best obscure

The hysteria of it all, involving and absorbing as it does so totally our available sources of news, engenders clinical curiosity about mob psychology. The curiosity quickly turns to anxiety when one considers the relative ease with which an entire group of supposedly sophisticated, alert and ordinarily wary journalists has been influenced to a blinded preoccupation, if not prejudiced, on the Watergate affair.

Perhaps the profession of journalism has become sterile. Reliance on canned sources such as wire services has made enterprising reporters and discriminating editors unnecessary. Computerized news now hardly need be examined by human eyes before it tumbles neatly bundled from the presses onto loading platforms. The greatest part of any local editorial page is made-up of syndicated columns, the political and philosophical coloring of which can be changed by simply ordering a new mix or blend as one might change brands of underarm deodorant.

TV news coverage on any channel is made-up primarily of network tape clips strung together and punctuated by inane remarks from commentators who need be, and occasionally are, little more than nincompoops.

God knows, the President has given doctors little to cheer about and no reason at all to defend him. He, through his various Economic

Phases, has managed to discriminate unfairly against doctors; his appointees now harass us on PSRO, and we are probably justified in feeling apprehensive about the possibility of his bargaining us right into bondage in some National Health Insurance scheme. Nevertheless, we must give him, grudgingly or otherwise, the same respect and admiration we give any animal at bay and actively defending itself.

It is not solely in an effort to even up the sides in this grossly unfair contest that we bring these matters to your attention. We would like to see the present preoccupation with the Watergate Affair end simply because it is in the best interest of all of us to have it end. Domestically, the attention of our legislators is certainly needed on problems such as inflation, scarcities, and irresponsible federal over-spending. Internationally, it is not good for us to be caught with our leader's attention riveted so firmly in one spot. In such a posture we can expect to have our resolve tested in a variety of ways some of which, such as the oil embargo, we have already seen.

For what it is worth, Mr. President, here is one editorial writer solidly in support of you. Whatever dispute we have with you, we will take up at a mutually more convenient time.

EFFECT OF DIGITALIS ON CARDIAC HYPERTROPHY

The effect of digitalis on cardiac hypertrophy has been recognized for many years. Christian[1] as early as 1933 pointed out that digitalis is administered daily to patients with cardiac hypertrophy produced beneficial effects. He believed that cardiac enlargement was harmful and that digitalis not only retarded enlargement, but also delayed the appearance of symptoms and signs of cardiac insufficiency.

In 1965 Williams and Braunwald[2] published data which tended to support Christian's point of view. These workers reported that digitoxin administered to rats in which the aorta had been experimentally restricted developed a significantly lesser degree of myocardial hypertrophy than those which had not received digitoxin. Recent work[3] in which a more physiologic method of producing cardiac enlargement, namely by use of hypoxia, further substantiated the view set forth by Christian. Digitoxin administered daily to rats which were subjected to significant degrees of hypoxia prevented left ventricular hypertrophy.

Although the exact mechanism by which digitoxin significantly decreases cardiac enlargement during exposure to hypoxia is not entirely understood, certain factors may be mentioned. It is thought that cardiac glycosides lessen the hemodynamic burden of the heart; the contractile force of the ventricle is increased so that the capacity of cardiac muscle to do work is augmented. Another factor is that cardiac glycosides increase the capacity of the contractile proteins for converting energy into mechanical work. Whatever the exact mechanism is, there is no doubt but that digitoxin is quite capable of significantly reducing the amount of cardiac enlargement when the heart is under marked stress.

The bearing of these experimental studies on clinical medicine is apparent and clinicians treating patients with cardiomegaly might keep the studies in mind. Perhaps one extrapolation may be permitted, namely that individuals who have certain lesions of the left ventricle may be benefited if a cardiac glycoside were administered in the event that they were exposed to altitude.

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1. Christian, H. A., J. A. M. A. 100: 789, 1933.
2. Williams, J. F., Jr. and Braunwald, E. Am. J. Cardiol. 16: 534, 1965.
3. Van Liere, E. J., Roberts, S. K., Sizemore, D. A. and Stickney, J. C. Proc. Soc. Exp. Biol. and Med. 145: 220, 1974.

Today's Medicine Costs Less

An individual tablet or capsule of prescription medicine cost the consumer, on average, 2.3 per cent less in 1973 than in 1971 — and 6 per cent less than in 1960 — encompassing a period of acute inflation in the general economy, according to a report of the Pharmaceutical Manufacturers Association (PMA).

The decrease in unit price is recorded in data prepared by Professor John Firestone of the City University of New York. Dr. Firestone's figures indicate a 3 per cent rise in the retail price of an average prescription during 1973, but the average prescription size rose 4.2 per cent — hence the actual decline in cost when measured in single tablet or capsule units.

In addition to measuring changes in average prescription size, and in the average price of a size-adjusted prescription, Professor Firestone has also prepared conventional retail and wholesale price indices for prescription pharmaceuticals. His retail index indicates a rise of 0.3 per cent since 1972 and of 3.2 per cent since the base year 1967. When 1960 is used as a base year a decline of 7.7 per cent is found.

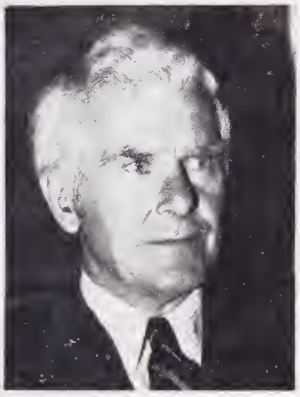
Bureau of Labor Statistics data paint an even more impressive counter inflation picture for pharmaceutical products, showing a decline of 0.4 per cent last year, and 12.8 per cent since 1960.

GENERAL NEWS

Two Additional Speakers Selected For 107th Annual Meeting

The Program Committee has announced that two prominent physicians have been added to the list of guest speakers for the 107th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 21-24.

Dr. J. Hugh Wiley of Morgantown, Chairman of the Program Committee, announced that Drs. Robert F. Schilling of Madison, Wisconsin, and Charles H. Kirkpatrick of Bethesda, Maryland, will present papers during the meeting.



Robert F. Schilling, M. D. Charles H. Kirkpatrick, M. D.

Doctor Schilling will present a paper at the second general scientific session on Friday morning, August 23, and Doctor Kirkpatrick will participate in a "Symposium on Newer Concepts in Infectious Diseases" at the first general scientific session on Thursday morning, August 22. His subject will be "Immunotherapy of Chronic Infectious Diseases."

Robert F. Schilling, M. D.

Dr. Robert F. Schilling, who is Washburn Professor of Medicine at the University of Wisconsin Medical School, is a native of Adell, Wisconsin.

He was graduated from the University of Wisconsin and received his M.D. degree in 1943 from the University of Wisconsin Medical School. He interned at Philadelphia General Hospital prior to serving as a Battalion Surgeon with the Medical Corps of the U. S. Marines from 1944 to 1946. He served a two-year residency in medicine at University Hospitals in Madison, Wisconsin, and was a Research Fellow in Medicine for two years at Harvard Medical School. He also served as Assistant in Medicine during that same period at Boston City Hospital.

He joined the faculty of the University of Wisconsin Medical School in 1951 and was named Professor of the Department of Medicine in 1962. He was named Chairman of the Department and served in that position from 1964 to 1971.

He was certified by the American Board of Internal Medicine in 1951 and served as a member of its Board of Directors from 1968 to 1971. He is a member of Phi Beta Kappa, Alpha Omega Alpha and serves as a member of the Editorial Board of *Journal of Laboratory and Clinical Medicine*. He also is a member of the Council of the American Society of Hematology.

Charles H. Kirkpatrick, M. D.

Dr. Charles H. Kirkpatrick, Senior Investigator and Head of the Section of Allergy and Hypersensitivity, National Institutes of Health, Bethesda, Maryland, is a native of Topeka, Kansas.

He was graduated from the University of Kansas and received his M. D. degree in 1958 from the University of Kansas School of Medicine. He interned at the University of Illinois Research and Educational Hospital in Chicago, served a residency in medicine at the University of Kansas Medical Center; and was a Fellow in Allergy and Immunology at the University of Colorado Medical Center in Denver from 1962 to 1965. He also served on the faculty at that Center while in Denver and then returned to the University of Kansas Medical Center where he served as a member of the faculty from 1965 to 1968. He accepted his present position at the National Institutes of Health in 1968.

Doctor Kirkpatrick was Certified by the American Board of Internal Medicine in 1965 and the Subspecialty Board for Allergy in 1969. He has served as a member and chairman of a number of committees related to allergy and was Chairman of the International Committee of the American Academy of Allergy in 1973. He also is a member of that organization's Weather and Air Pollution Committee.

Scientific Program Nearly Completed

It was announced previously that the following physicians had accepted invitations to present papers during the three general scientific sessions:

James F. Glenn, M. D., Professor and Chief of the Division of Urologic Surgery, Duke University Medical Center, Durham, North Carolina.

Allen H. Mackenzie, M.D., Staff Member of the Division of Medicine — Department of Rheumatic Disease — Cleveland Clinic Foundation, Cleveland, Ohio.

Virgil M. Howie, M.D., Pediatrician, Huntsville, Alabama.

The name and photograph of one other speaker will be published in the July issue of *The Journal.*

Two Honor Guests

Sen. Robert C. Byrd of West Virginia, Majority Whip of the United States Senate, will deliver the "Thomas L. Harris Address" at the opening of the first general scientific session on Thursday morning, August 22.

Dr. Malcolm C. Todd of Long Beach, California, who will be installed as President of the American Medical Association at the Annual Meeting in Chicago this month, will speak at the first session of the House of Delegates on Wednesday afternoon, August 21.

Doctor McCoy to Deliver Address

Dr. A. Thomas McCoy of Charleston, President of the State Medical Association, will deliver his Presidential Address at the second and final session of the House of Delegates on Saturday afternoon, August 24.

Saturday Morning Session

The first portion of the general scientific session on Saturday morning will center around a discussion of the development and future plans for the Department of Family Practice at the West Virginia University School of Medicine. The speaker will be Dr. John W. Traubert, Chairman of the Department.

The remainder of the morning program will be devoted to a Symposium on "What Are the Barriers to an Improved Medical Practice in the State of West Virginia."

Doctor Wiley indicated that such subjects as malpractice, PSRO and other timely topics will be open for discussion during the Symposium. Doctor Wiley once again has asked that physicians in the State be urged to let him know in advance what subjects should be included on the agenda. He said this would aid the Committee in arranging to have appropriate persons on hand to field the questions.

Recreational Activities Planned

The Committee purposely has attempted to leave the afternoon hours relatively free of committee meetings to enable physicians and their families to enjoy the many recreational facilities at The Greenbrier. As usual, there will be golf and tennis tournaments and preliminary plans are being worked out for a skeet shooting tournament as well as a fishing derby.

Room Reservations Pass 450 Mark

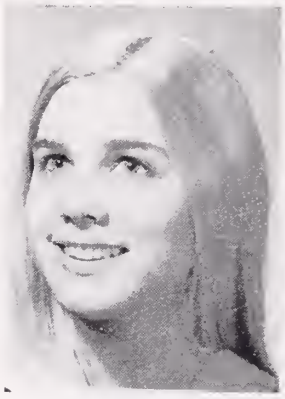
The number of room reservations at The Greenbrier for the Annual Meeting in August has passed the 450 mark and it is anticipated that more than 700 persons including physicians, their wives and guests will be in attendance. All physicians who plan to attend the meeting are urged to make reservations as soon as possible.

Additional information concerning the 107th Annual Meeting will be published in the July and August issues of *The Journal.*

Four Young Students Awarded Medical Scholarships

Four young West Virginia students have been awarded four-year scholarships to the West Virginia University School of Medicine by the West Virginia State Medical Association.

Dr. Martha Jane Coyner of Harrisville, Chairman of the Association's Committee on Medical Scholarships, announced that the recipients of this year's awards will be as follows:



Miss Patricia J. Zekan

Edward E. Wright

Patricia J. Zekan of Charleston, Edward E. Wright of Pine Grove, Dale R. Pokorney and Edwyn L. Boyd, both of Wheeling. The recipients of the scholarships will receive $1,000 for each of the four years while enrolled in the School of Medicine.

The four students have been accepted by the School of Medicine to begin studies this fall leading toward M.D. degrees.

Miss Zekan was graduated from Morris Harvey College and received a Master's degree from Duke University. She taught for a year at Woodrow Wilson Junior

Dale R. Pokorney

Edwyn L. Boyd

High School in Charleston. She is the daughter of Mrs. Verna M. Zekan and the late Dr. John G. Zekan.

Wright, who received an A.B. degree in biology from West Virginia University last year, is the son of Mrs. Margaret Wright and the late Glenn E. Wright of Pine Grove.

Pokorney was graduated from Johns Hopkins University this year and he is the son of Mr. and Mrs. Sidney Pokorney of Wheeling.

Boyd graduated from Marshall University in May and he is the son of Mrs. June L. Collins of Wheeling.

Doctor Coyner noted that the four scholarships awarded this year bring to 32 the total number of scholarships which have been awarded to deserving students since the State Medical Association started the program in 1958.

Until this year the Association awarded two scholarships annually but the number was increased to four for the purpose of recruiting more physicians for West Virginia. Under the terms of the scholarships, recipients must agree to practice in West Virginia for four years following graduation, completion of postgraduate training and military obligations.

The full Medical Scholarships Committee met in Morgantown on Saturday and Sunday, April 27-28, to interview applicants for the grants.

Committee members present for the interviews were the Chairman, Doctor Coyner, and Drs. Russel Kessel and Marshall J. Carper, both of Charleston; Robert D. Hess of Bridgeport; Thomas J. Holbrook of Huntington; John Mark Moore of Wheeling; and Clark K. Sleeth of Morgantown. Also present to assist the committee was Mr. Custer B. Holliday, a member of the staff of the State Medical Association.

West Virginia Physicians to Attend AMA Convention In Chicago

A number of West Virginia physicians will be among some 9,000 physicians attending the 123rd annual convention of the American Medical Association June 22-27 in Chicago.

The West Virginia State Medical Association's two Delegates to the AMA House of Delegates are Drs. Richard E. Flood of Weirton and Frank J. Holroyd of Princeton, with Drs. George R. Callender, Jr., of Charleston, and Harry S. Weeks, Jr., of Wheeling, as Alternate Delegates.

The business meeting of the AMA House starts on Sunday, June 23 at the Palmer House and is slated to end Thursday, June 27.

A few feature of the 1974 convention will be a series of fireside forums. They will be informal evening presentations at the downtown Hyatt House Hotel in which participants will visit one of six Chicago medical schools via half-hour videotapes made by the faculty working with equipment and patients.

Another innovative program feature will be a special session on how to make a medical motion picture.

Richard E. Flood, M. D.

Frank J. Holroyd, M. D.

A total of 54 scientific sessions are scheduled, in addition to 36 postgraduate courses. Eight postgraduate courses open the scientific program on Saturday, June 22, which runs through Wednesday, June 26.

There will be an array of exhibits, both scientific and industrial, and the presentation of 30 medical films.

The bulk of the scientific sessions will be held in McCormick Place, Chicago's lakefront convention center.

Malcolm C. Todd, M. D., of Long Beach, California, will take office during the convention as new President of the AMA, succeeding Russell B. Roth, M. D., of Erie, Pennsylvania

During the week the AMA will present its highest honor — the Distinguished Service Award — to William F. House, M. D., of Los Angeles. Doctor House, a specialist in ear problems, has combined the private practice of medicine with basic research, clinical research and graduate and postgraduate education.

Harry S. Weeks, Jr., M. D.

Geo. R. Callender, Jr., M. D.

The AMA's Layman's Citation for Distinguished Service will be presented to Nathan J. Stark of Kansas City, Missouri. Mr. Stark has been President of the Kansas City General Hospital and Medical Center Corporation and has held other important hospital leadership positions.

Dr. Robert E. Olson, Chairman and Professor of Biochemistry at St. Louis University Medical Center,

will receive the Goldberger Award for outstanding work in nutrition.

Among Exhibit Hall highlights at McCormick Place will be several new features, including the Journal of the American Medical Association's filmed clinical pathological conferences, which will be shown for the first time. There will be a cardiopulmonary resuscitation exhibit and course in basic life support. The fresh tissue pathology exhibit will mark its 75th anniversary at an AMA scientific program.

In the postgraduate arena, seven courses will be conducted by the American Society of Clinical Pathologists, designed to assist the non-pathologist physician. Other courses include: life-saving measures for the critically injured; diagnosis and management of common kidney diseases, dermatology, urology, human sexuality, gynecology, drugs in the emergency room, and sports medicine and athletic injuries.

Highlighting a number of new scientific programs will be a study of the practitioner's approach to angina.

Full details of the AMA program were published in the April 15 issue of *The Journal of the American Medical Association.*

Alcoholism, Drug Abuse Seminar Scheduled June 16 At WVU

A "Physicians' Seminar on Alcoholism and Drug Abuse" will be held on Sunday, June 16, in the Auditorium of the Medical Center, West Virginia University, in Morgantown.

The one-day seminar is being sponsored by the Division on Alcoholism and Drug Abuse, West Virginia Department of Mental Health, and the Department of Behavioral Medicine and Psychiatry, WVU School of Medicine.

Nationally prominent guest speakers will be Donald W. Goodwin, M.D., Associate Professor of Psychiatry, Department of Psychiatry, Washington University School of Medicine, St. Louis, Missouri, and Chaim M. Rosenberg, M.D., Ph. D., Boston City Hospital and Assistant Professor of Psychiatry, Harvard Medical School, Boston.

Serving on a Reactor Panel will be Drs. Donald P. Brown of Kingwood, Immediate Past President of the West Virginia Academy of Family Physicians; John W. Traubert, Chairman of the Department of Family Practice, WVU School of Medicine; Robert D. Hess of Bridgeport, Family Physician, and James M. Stevenson, Director, Adult Out-Patient Services, Department of Behavioral Medicine and Psychiatry, WVU.

Other participants will be M. Mitchell-Bateman, M.D., Director, West Virginia Department of Mental Health, and W. W. Spradlin, M. D., Professor and Chairman of the Department of Behavioral Medicine and Psychiatry at WVU.

Mr. Raymond E. Washington is Director of the Division on Alcoholism and Drug Abuse for the State Department of Mental Health.

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled in the coming months.

1974

June 3-6—Int. Convo. Immunology, Buffalo, N. Y.
June 9-13—International Thyroid Conf., Boston.
June 10-12—Am. Neuro. Assn., Boston.
June 11-14—Soc. of Nuclear Med., San Diego.
June 15-16—Am. Diabetes Assn., Atlanta.
June 20-21—Soc. for Vascular Surgery, Chicago.
June 22-23—Am. Assn. Study of Headache, Chicago.
June 23-27—AMA, Chicago.
June 24-26—Am. Coll. Preventive Med., Chicago.

July 10—Breast Feeding Sem., Chicago.
July 14-20—Radiation Research Soc., Seattle.
July 25-27—Am. Electroencephalographic Soc., Seattle.
July 28-Aug. 1—Natl. Med. Assn., N. Orleans.
July 28-Aug. 2—Int. Assn. Child Psychiatry & Allied Professions, Phila.

Aug. 2-4—International Doctors in AA, O'Hare Airport (Inn).
Aug. 12-15—Am. Hosp. Assn., Chicago.

Aug. 21-24—107th Annual Meeting, W. Va. State Medical Assn., White Sulphur Springs.

Sept. 4-7—Am. Assn. Ob.-Gyn., Hot Springs, Va.
Sept. 5-7—Tri-State Otolaryngology Meeting, Sea Island, Ga.
Sept. 9-11—AMA Congress Occupat. Health, Chicago.
Sept. 16-19—Ky. Med. Assn., Louisville.
Sept. 18-20—Int. Symp. Epidemiology of Hypertension, Chicago.
Sept. 18-21—Am. Thyroid Assn., St. Louis.
Sept. 20-21—Symp. on Neonatology, El Paso.
Sept. 24-27—Am. Roentgen Ray Soc., San Francisco
Sept. 27-28—Am. Heart Assn., W. Va. Affiliate, Annual Meeting & Scientific, Wheeling.
Sept. 27-Oct. 2—Internat. Coll. of Surgeons, Portland.

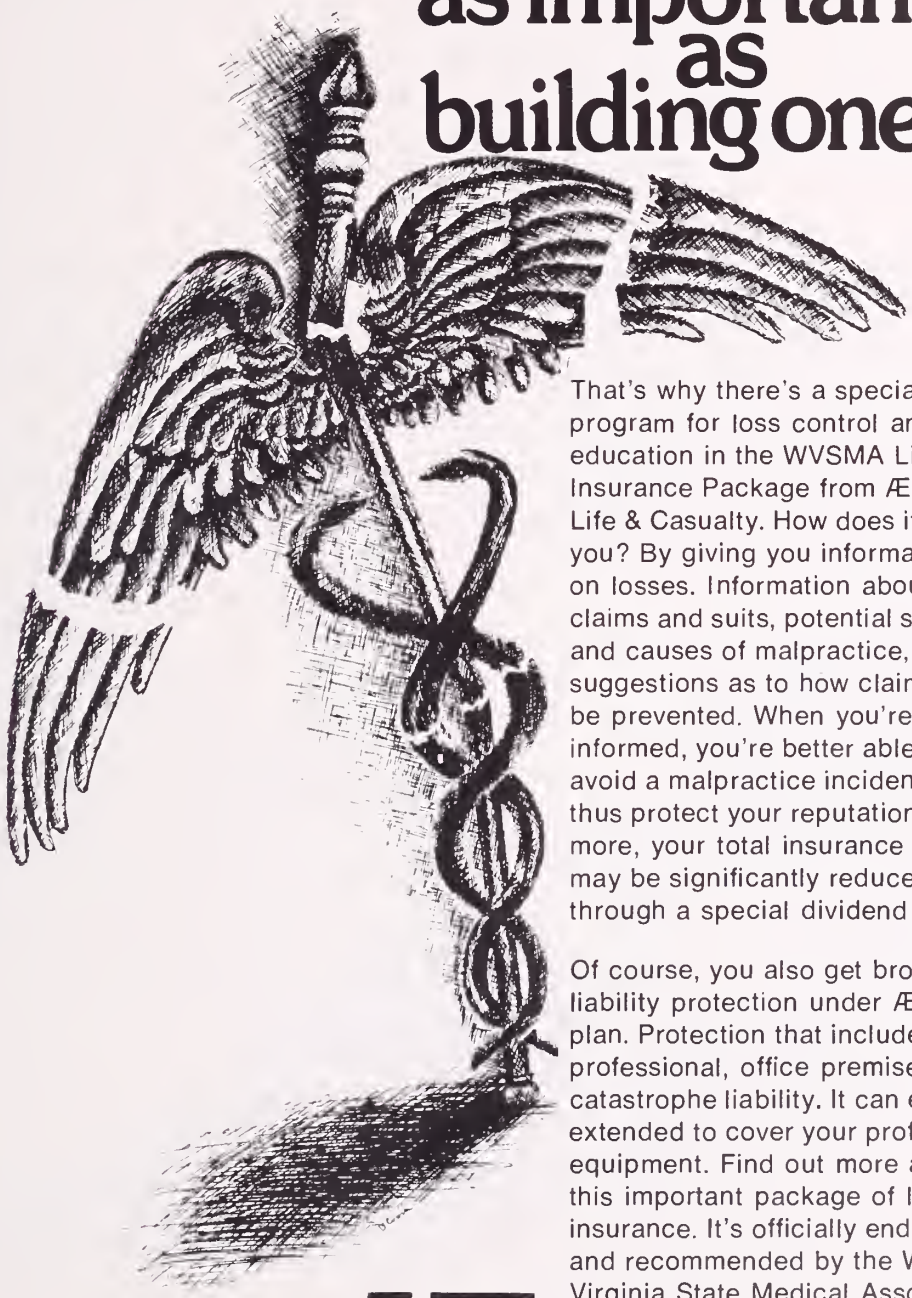
Oct. 5-8—Am. Assn. of Ophthalmology, Dallas.
Oct. 6-10—Am. Acad. Oph. & Otol., Dallas.
Oct. 14-17—AAFP, L. A.
Oct. 16-18—Am. Cancer Society, New York.
Oct. 17-19—Am. Assn. for Surgery of Trauma, Hot Springs, Va.
Oct. 19-24—Am. Acad. Pediatrics, San Fran.
Oct. 21-25—ACS Clinical, Miami Beach.
Oct. 23-26—Pa. Medical Soc. Scientific, Harrisburg.
Oct. 29-30—Am. Assn. Study of Liver Diseases, Chicago.

Nov. 17-20—Southern Med Assn., Atlanta.
Nov. 30-Dec. 4—AMA Clinical, Portland.

1975

Jan. 24-26—8th Annual Mid-Winter Clinical Conf., Charleston.

Protecting a reputation is as important as building one.



That's why there's a special program for loss control and education in the WVSMA Liability Insurance Package from Ætna Life & Casualty. How does it help you? By giving you information on losses. Information about actual claims and suits, potential sources and causes of malpractice, even suggestions as to how claims might be prevented. When you're better informed, you're better able to avoid a malpractice incident and thus protect your reputation. What's more, your total insurance costs may be significantly reduced through a special dividend feature.

Of course, you also get broad liability protection under Ætna's plan. Protection that includes professional, office premise and catastrophe liability. It can even be extended to cover your professional equipment. Find out more about this important package of liability insurance. It's officially endorsed and recommended by the West Virginia State Medical Association. Contact your WVSMA office or your nearest Ætna Life & Casualty agent.

You get *action* with Ætna

The Standard Fire Insurance Company
Hartford, Conn.

Ætna
LIFE & CASUALTY

WVU Medical Center –News–

• **Compiled from material furnished by Mrs. Mary Ellin Wylie, Director, Medical Center News and Information Services, Morgantown, W. Va.**

PRESIDENT James G. Harlow announced recently that 141 faculty members at West Virginia University have been promoted in rank or granted tenure. The 29 from the School of Medicine who have been advanced, effective July 1, to the ranks listed are:

Ernest L. Abernathy, Clinical Professor, Pathology; William E. Anderson, Professor, Medicine; Ray A. Boone, Assistant Professor, Physical Therapy; Janice W. Cone, Assistant Professor, Behavioral Medicine and Psychiatry; Richard E. Goese, Assistant Professor, Medicine; H. Summers Harrison, Clinical Associate Professor, Pediatrics; Nancy J. Jennings, Clinical Assistant Professor, Radiology; John F. Kelley, Professor, Behavioral Medicine and Psychiatry and Pediatrics; Ordie H. King, Jr., Professor, Pathology; Peter R. Ladewig, Clinical Professor, Pathology.

Eugene S. LaPlante, Associate Professor, Surgery; Robert E. McCafferty, Professor, Anatomy; Barry J. Make, Assistant Professor, Medicine; Ronald J. Millecchia, Associate Professor, Physiology and Biophysics; David Z. Morgan, Professor, Medicine; Robert J. Nottingham, Clinical Associate Professor, Pediatrics; John J. Petronis, Assistant Professor, Physical Therapy; Arthur L. Poffenbarger, Clinical Associate Professor, Neurology; Robert S. Pope, Assistant Professor, Anatomy.

Robert S. Pore, Associate Professor, Microbiology; Chitraleka Ramanan, Assistant Professor, Pediatrics; Sundaram V. Ramanan, Associate Professor, Medicine; Harold Resnick, Professor, Biochemistry; Robert L. Robinson, Professor, Pharmacology; Mabel M. Stevenson, Professor, Pathology; Thomas J. Tarnay, Professor, Surgery; Erdogan Tercan, Associate Professor, Anesthesiology; O. Lee Trick, Professor, Behavioral Medicine and Psychiatry; Kenneth L. Wible, Assistant Professor, Pediatrics.

Ob.-Gyn. Chairman Appointed

Dr. Charles A. White Jr., a professor at the University of Iowa College of Medicine, will join the West Virginia University faculty on or before July 1 as Professor and Chairman of the School of Medicine's Department of Obstetrics and Gynecology.

WVU President James G. Harlow announced Doctor White's appointment to the post held since 1967 by Dr. Walter A. Bonney, Jr. Doctor Bonney who is entering private practice in Morgantown, will be affiliated with the School of Medicine as a Clinical Professor of Obstetrics and Gynecology.

Doctor White was born in San Diego, California. He attended San Francisco State College and the University of California at Davis. After a year of service in the Army, he entered Colorado State A & M College where in 1945 he received the D.V.M. degree. He spent six years in the private practice of veterinary medicine before attending the University of Utah where in 1955 he received his M.D. degree.

Doctor White was an intern at Salt Lake County General Hospital. After one year of residency in his specialty at Dee Memorial Hospital in Ogden, Utah, he served for two years as a Navy medical officer and then completed his residency in obstetrics and gynecology in 1961 at the University of Iowa Hospital. He has been a member of Iowa's College of Medicine faculty since that time.

The author or co-author of 34 scientific publications, Doctor White has been an examiner since 1971 for the American Board of Obstetrics and Gynecology from which he received certification in 1964.

Doctor White and his wife are parents of three children.

Dr. Anido Heads State Pathologists Group

Dr. Vicente Anido, Professor of Clinical Pathology and Director of Clinical Laboratories at WVU Medical Center, was named President of the West Virginia State Pathologists Association at its 1974 Spring Meeting in Morgantown.

Also elected to office were: Dr. John Sheils, Cabell-Huntington Hospital, Vice President; Dr. Karl L. Klapproth, Charleston Area Medical Center, Secretary-Treasurer; Dr. Cordell de la Pena, Clarksburg Veterans Administration Hospital, and Dr. Robert S. Salisbury, Assistant Professor of Clinical Pathology at WVU, members of the Board of Directors.

The 1975 Spring Meeting of the West Virginia State Pathologists Association will also be held in Morgantown.

First Cancer Society Junior Faculty Fellowship

Dr. Leonard L. Peters of the Department of Surgery has been selected as the first WVU recipient of an American Cancer Society Junior Faculty Clinical Fellowship.

Doctor Peters, who will complete his residency training in surgery this month, currently holds an ACS Clinical Fellowship. Such fellowships are intended to provide additional specialized clinical training in cancer, in quantity and depth, beyond that which would ordinarily be received in residency training programs.

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The Month in Washington

TRIGGERED by the surprise introduction of a Kennedy-Mills proposal for national health insurance and a major effort by the Nixon Administration to get its own bill through this year, the Congress has again started a hot and heavy debate on the complex issues involved.

Appearing before the House Ways and Means Committee, Russell B. Roth, M. D., President of the American Medical Association, warned that most of the congressional push for national health insurance (NHI) is based on the false premise that there is a health care crisis.

"The fact is," Doctor Roth told the Committee, "more people are receiving more and better medical care from more and better trained physicians in more and better equipped facilities than ever before in history. These are not elements of crisis. The fact also is that the public, as its opinion has been judged in various polls, does not perceive medical service to be a major problem area.

"No doubt the Committee recalls a recent Louis Harris poll, commissioned by a Senate subcommittee, which indicated that whereas 64 per cent of the sample identified inflation as our nation's most serious problem, health care rated 15th, or next to last on the list, with only 3 per cent of the respondents putting emphasis on this. Inasmuch as any of the proposals for extensions of federal subsidies for medical service are inevitably inflationary to some degree, one wonders about the advisibility of further aggravating this most serious problem in order to attack a problem of much lesser magnitude.

"Poll after poll confirms that people are generally satisfied with the type of health care they personally receive. This satisfaction relies on wide experience, for some 2.5 million people a day see a physician. A 1971 University of Chicago study, based on a nationwide sample, found 84 per cent of the people satisfied, only 10 per cent dissatisfied. Just last month a survey commissioned by the *Washington Post* uncovered a virtually identical pattern in this area. According to Mr. Jay Mathews' story, six of every seven local residents are at least "pretty satisfied" with their medical care. Only one person in ten expressed any measure of discontent. It would be an interesting exercise to see if you could find another issue or subject these days upon which Americans would voice 85 or 90 per cent agreement.

Ten Years of Substantial Progress

"Reflected in the results of the polls is a record of at least ten years of substantial progress. During this period the number of American medical schools and the number of physicians available to the American public have been increasing. Physician numbers will continue to increase at a pace which exceeds the general population growth rate."

Speaking strongly in support of the AMA sponsored Medicredit bill for NHI, Doctor Roth urged the Committee to follow the guiding principles developed by the AMA in its proposed legislation.

Kennedy-Mills NHI Proposal

Lashing out at the Kennedy-Mills NHI proposal, Dr. Roth said, "It is one thing to mandate the purchase of private insurance by employers. It is something quite different to institute increased payroll taxes, destroy the future of private insurance and shift a well-regarded private function into a federal agency.

The financing envisioned in the Kennedy-Mills proposal gives us several problems:

"It creates a massive four per cent increase in the Social Security tax. Wage earners will not be deluded by the fact that three per cent is to be paid by employers and one per cent by employees. The Public is sophisticated enough to know that there is no free ride in this respect and the source of the funds to pay for such federal programs is from their compensation.

"We would point out further that under Social Security taxes, he who earns $20,000 a year pays the same as the person who earns 90 or 100 thousand. In our view, it would be more equitable for those who make more to pay more. We would prefer the sort of consistent sliding scale approach that is embodied in the Medicredit bill. Finally, we would seriously question the proposition that by eliminating the profit factor Social Security handling of health insurance finances will bring economies and efficiencies.

"The track record of government — our own and others as well — provides scant historical evidence that its capacity to manage surpasses private management in terms of either efficiency or economy.

"Administrative control derives in large part from financing mechanisms, and, since we advise strongly against control of a new program by the Social Security Administration, we would avoid Social Security financing."

• **From the Washington Office of the American Medical Association.**

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Obituaries

BERNARD W. WILKINSON, M. D.

Dr. Bernard W. Wilkinson, family physician and surgeon in Clarksburg for 42 years, died on April 1. He was 71.

A native of Cottageville, in Jackson County, Doctor Wilkinson was a graduate of West Virginia University and received his M. D. degree in 1929 from the Medical College of Virginia. He also served a residency in surgery at the latter institution.

Doctor Wilkinson was a member and a Past President of the Harrison County Medical Society, and a member of the West Virginia State Medical Association and the American Medical Association.

Survivors include the widow, four sons, Bernard W. Wilkinson, Jr., at home; Amos W. and Stuart W. Wilkinson, both students at West Virginia University, and Brooks W. Wilkinson, student at Boston University; two daughters, Mrs. Allen Pois of Madison, Wisconsin and Dr. Caroline Jane Wilkinson of Chicago, and three sisters, Mrs. Hazel Rogers of Lumberport, Mrs. Beatrice Tate of Mannington and Mrs. P. L. Ingram of St. Marys.

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JAMES B. PURKALL, JR., M. D.

Dr. James B. Purkall, Jr. of Bluefield died on April 24 in a hospital there. He was 51. Doctor Purkall, who had lived in Bluefield for the past five years, was Head of the Radiology Department at Bluefield Sanitarium Clinic.

A native of Augusta, Georgia, Doctor Purkall graduated from Mercer University at Macon, Georgia. He received his M. D. degree in 1946 from the Medical College of Georgia. He interned at New Hanover Hospital in Wilmington, North Carolina and served a residency in radiology at the Medical College of Virginia.

Doctor Purkall was a member of the Mercer County Medical Society, the West Virginia State Medical Association and the American Medical Association.

Surviving are the widow, two sons, James B. Purkall, III of Alexandria, Virginia and Donald B. Purkall of Richmond, Virginia, and one sister, Mrs. Maude Ella Shirley of Torrence, California.

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JOHN M. BROWN, M. D.

Dr. John M. Brown of Shinnston died on April 18 in a Clarksburg hospital.

A native of Craigsville, Doctor Brown previously had practiced in Alderson from 1935 to 1957, when he went to Shinnston.

He was a graduate of West Virginia University and received his M. D. degree in 1934 from the Medical College of Virginia.

Survivors include the widow, his mother, Mrs. Elizabeth Huff Brown of Spencer; one son, John B. Brown of Middleton, New Jersey; two daughters, Victoria Brown of Denton, Maryland and Mrs. Sheldon Hopkins of Ashland, Ohio; five brothers, Drs. Dudley Brown and Robert Brown of Romney, and Drs. F. H. Brown of Summersville, Paul Brown of Alderson and William Brown of Sutton, and two sisters, Mrs. William Jergens of Spencer and Mrs. Robert Jacobson of Lewisburg.

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ROY O. HALLORAN, M. D.

Dr. Roy O. Halloran, a skin specialist in Charleston since 1932, died on April 30 at his home following a short illness. He was 67.

A native of Hinton, Doctor Halloran was a graduate of West Virginia University and received his M. D. degree in 1931 from the Medical College of Virginia.

He interned at Hinton Hospital and did postgraduate work at the New York Skin and Cancer Hospital.

Doctor Halloran was a member of the Kanawha Medical Society, the West Virginia State Medical Association and the American Medical Association.

Survivors include the widow, two sons, Roy D. and Timothy C. Halloran, both of Charleston; one sister, Mrs. Fern Broddus of Beckley, and two brothers, Percy Halloran of Talcott, in Summers County, and Earl T. Halloran of Hinton.

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ARTHUR A. SHAWKEY, M. D.

Dr. Arthur A. Shawkey, retired Charleston pediatrician who began practice there in 1900, died on April 22 in a Charleston hospital. He was 103.

Doctor Shawkey was born on August 23, 1870, in Sigel-Jefferson County, Pennsylvania.

He received his M. D. degree in 1900 from the College of Physicians and Surgeons in Baltimore, and had additional training at New York Post Graduate Medical School and Harvard Medical School.

He was licensed to practice medicine in West Virginia in 1900 and he entered family practice in Charleston that same year. From 1916 until his retirement in 1959 he limited his practice to pediatrics. Through the years he served as Chief of the Pediatrics Department at the Kanawha Valley Hospital, St. Francis Hospital and the Salvation Army Hospital. He also served as Chief of the Pediatrics Department and Instructor in Pediatrics at the Nurses Training School of Mountain State Hospital.

Doctor Shawkey was a Past President of the Kanawha Medical Society and served two terms as Vice President of the West Virginia State Medical Association. He was an honorary member of the American Medical Association and a Fellow of the American College of Physicians and the American Academy of Pediatrics. He was a Diplomate of the American Board of Pediatrics.

Surviving are one son, Dr. George A. Shawkey of Charleston, and two daughters, Mrs. Elouise S. Harvey of Princeton, New Jersey and Dr. Anabel S. McConnell of Kingsport, Tennessee.

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County Societies

MONONGALIA

The Monongalia County Medical Society met on April 2 at the International Club in Morgantown. The scientific program was presented by John E. Jones, M. D., Professor of Medicine and Dean of the West Virginia University School of Medicine, who spoke on "Exciting New Events in Endocrinology."

The membership defeated a resolution presented by the Public Health Committee concerning mandatory Rubella antibody determination in premarital examinations.—William C. Klingberg, M. D., Acting Secretary.

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CABELL

Dr. Theodore M. King of Baltimore presented the scientific program at the meeting of the Cabell County Medical Society on April 11. Doctor King, who is Professor and Director of Gynecology and Obstetrics at Johns Hopkins University School of Medicine, spoke on "Utilization of Drugs in Pregnancy."

It was announced that arrangements have been made with the Kanawha Medical Society to hold a combined meeting in June at the Guyan Country Club in Huntington with the Cabell Society acting as host. —Charles H. McKown, Jr., M. D., Secretary.

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MERCER

Dr. A Thomas McCoy of Charleston, President of the West Virginia State Medical Association, was guest speaker at the meeting of the Mercer County Medical Society on April 15 at Frankie's La Salute Club.

Doctor McCoy gave an interesting talk on "The Revolution in Medicine with Third Party Medicine."

Dr. T. Keith Edwards of Bluefield, reporting for the Continuing Education Committee, said it is hoped that a continuing education course can be initiated at the three hospitals in Mercer County.—John J. Mahood, M. D., Secretary.

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McDOWELL

The McDowell County Medical Society met on April 10 at the Stevens Clinic Hospital in Welch.

A letter from the Department of Membership Development of the American Medical Association was read answering certain questions which had been submitted by our Society regarding membership in the AMA and county and state Societies. Among the answers given by the AMA was the observation that in one situation mentioned by this Society a change in its By-Laws would be necessary.

A letter from the Executive Secretary of the West Virginia State Medical Association was read advising that the next few issues of *The West Virginia Medical Journal* probably would be delayed because the Association was in the process of working with a new printer.—Arthur A. Carr, M. D., Secretary.

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PHYSICIAN WANTED—An experienced practitioner to add to and work with an established group in Charleston. Excellent working conditions with regular hours and minimal night work. Liberal vacation, sick leave and holiday program. Pension plan, Social Security, and professional liability insurance coverage. Apply Charles E. Staats, M. D., 123 West Washington Street, Charleston, W. Va. 25302—Telephone 346-0381 Area Code 304.

WANTED—Internist urgently needed in a growing northeastern West Virginia community; drawing area is approximately 23,000; modern hospital with excellent facilities; office space available; guaranteed annual income; centrally located for vast recreational facilities. Write RLH, The West Virginia Medical Journal, P. O. Box 1031, Charleston, W. Va. 25324.

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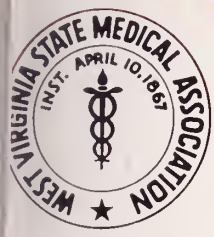

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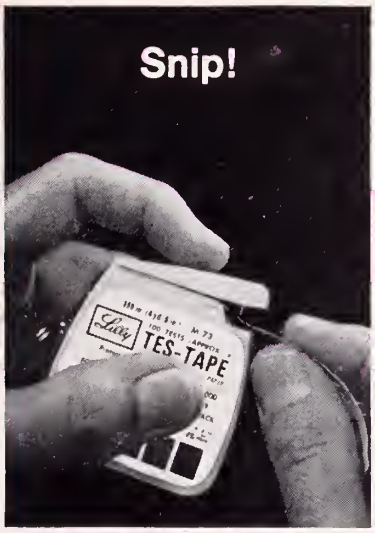

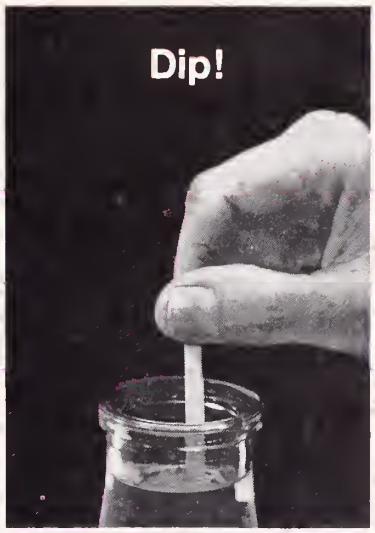

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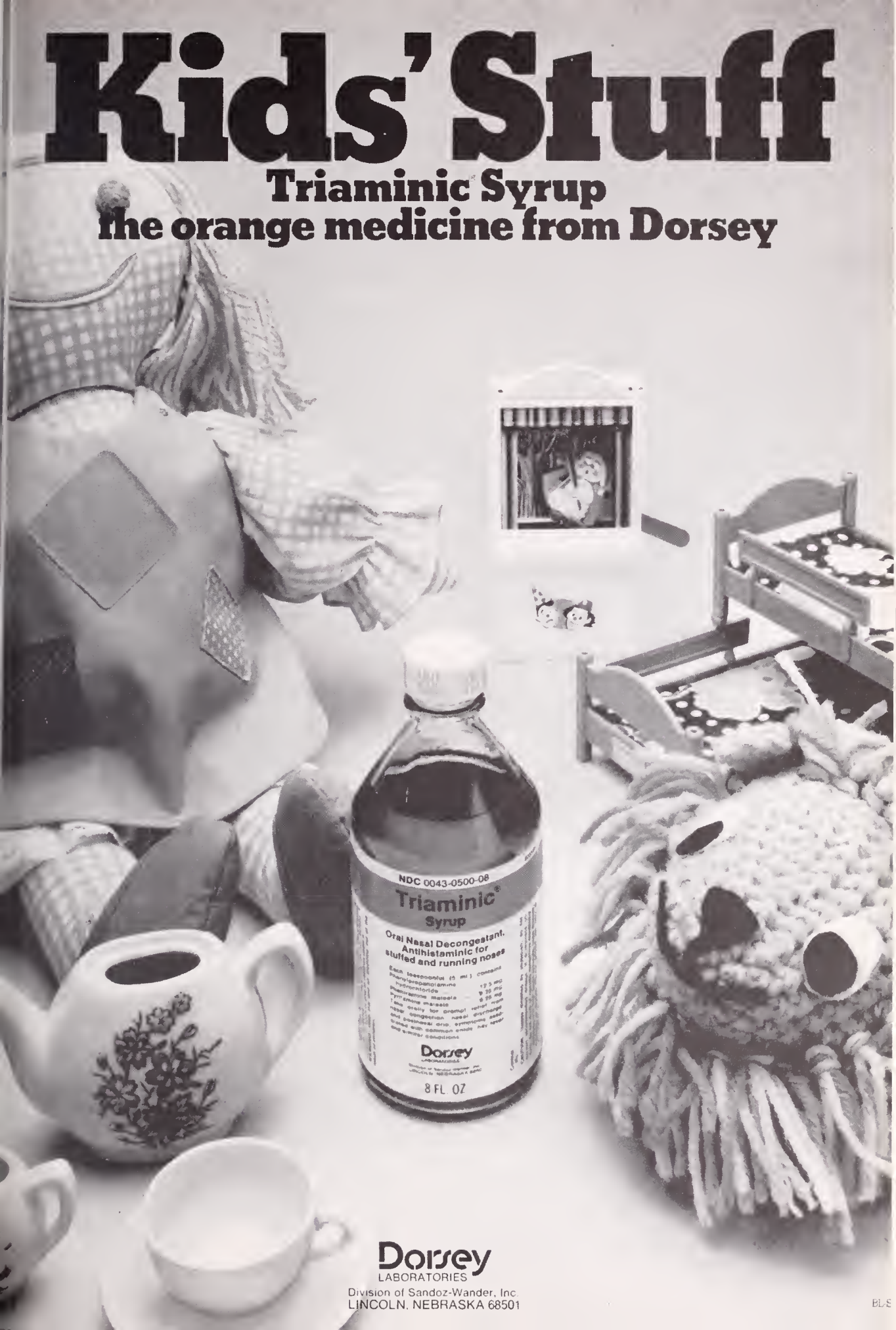

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Opinion & Dialogue

Is there a need for a drug compendium?

Government Health Official

Henry E. Simmons, M.D.
Deputy Assistant Secretary for Health
Department of Health, Education and Welfare

A drug compend of the type I envisi would fill a definite need for the prac ing physician. Su compendium wo give him all information n essary for us a drug intelligently, and it woul do so in a clear, concise, convenient, objective and balanced fashion.

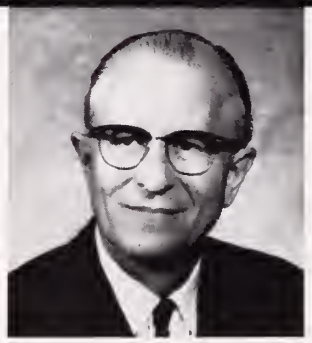
What a Compendium Should Contain

I believe the compendium should inform the doctor what a drug will do, when he should us for what type of patient, for how long, in what dose, what benefit his patient is likely to obtain, th risks involved, and cross-reacti with other drugs.

The information would be based on the package insert an have the same legal status. In fa a complete compendium with c plete and current information might even eliminate the neces

Maker of Medicine

Joseph F. Sadusk, Jr., M.D.
Warner-Lambert Company



A drug compendium, or preferably compendia, should, believe, be private, not federal, sponsorship. They should conta comprehensive listings of drugs available for prescribing. They should be single, legibly printed volumes of reasonable size, updated quarterly or semiannually and completely revised every ye

Function of a Compendium

A compendium should furnish the following information o drugs in the following order: indi tions for use, side effects, adver drug reactions, contraindication drug interactions, drug dosage a the dosage forms marketed. Dru prices should not be included be cause they vary so widely and change rapidly.

No compendium should se forth drugs of choice or discuss relative efficacy. Such question must be left for the practicing p sician to decide, whether on the basis of the medical literature, h own clinical experience, advice colleagues, information supplie by manufacturers, and so on.

Nor should a compendium undertake to educate the doctor how to use drugs. Rather, it mus be a reference source designed p marily to refresh his memory as drugs he may not use regularly.

ckage insert in many in-
. This would constitute a
tial saving for the manu-
.

/ a complete compendium,
mean a volume of prohibi-
e. You don't need a book
ing 25,000 products with
mous amount of repetition.
drugs should be arranged
s. Mutually applicable infor-
would be provided, along
ief discussions pinpointing
nces in specific drugs of
ss. Listings would be cross-
d in a useful way.

Available Documents as s of Information

xisting references such as
nd the AMA Drug Evaluation
viously useful but they are
plete. Either they are not
eferenced by generic name
not group drugs with simi-
racteristics, or they do not
the available and legally
ted drugs. And some of
omitted may be very useful.

On the other hand, drugs made by more than one supplier, tetracycline for example, may be fully described a dozen times in the same book.

While perhaps PDR could be rearranged and cross-indexed with generics included, and while the AMA Drug Evaluation might also be modified and expanded, I am not sure that the end result would have all the attributes required for a useful compendium. At the same time, you would run the risk of amassing a voluminous and unwieldy tome.

Should Editorial Comments Accompany the Listings?

Subjective judgments, in my opinion, have no place in a compendium. However, if there is substantial evidence based on a sound body of science concerning relative efficacy of several drugs, certainly that information should be included. The committee of experts compiling and editing a particular section would also have to assess and indicate instances where a meaningful difference between drugs is pertinent.

Sponsorship, Compilation and Editing

Producing a book like this would undoubtedly be difficult and demanding. It would obviously take a great deal of talent and expertise, and would require a varied and experienced group, ranging from writers and editors to highly skilled clinicians and pharmacologists. Style, format and clarity of language would play an important part in determining the usefulness of the book. And it should be updated periodically and completely revised annually.

I have no opinion whether the government or the private sector should sponsor and/or finance the compendium. What is most important is that the compendium be an authoritative, objective and useful source of information for the doctor to have at hand as a ready reference.

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d in no way imply control over
actitioner's prerogatives.

nother Compendium?

A practicable, single-volume
endium cannot, nor is it
ssary to, include all drugs on
arket today. From my prac-
f internal medicine for some
ars, my experience as a con-
nt, and as a faculty member
r or five medical schools, I
d estimate that a doctor uses
30 to 35 drugs regularly. The
Physicians' Desk Reference,
entally, contained about
0 entries.

As to whether there should be
eral compendium, in my opin-
as stated earlier, the answer is
—there should *not* be one. The
osal assumes that existing
pendia are inadequate. We're
sure of that at all. Whatever its
erfections, the present drug
rmation system in the U.S. is
, multifaceted, pluralistic and
nsive. Good compendia exist,
ell as other ample sources on
g therapy, ranging from journal
ature through AMA Drug Evalu-
n to company materials. Not
hysicians may use such
rces as often or as well as they
uld, but that is the fault of the
, not of the sources.

In any event, rather than produce another book, it makes much more sense to work on improving existing compendia, and perhaps they could, as knowledge advances, include more accumulated clinical data and experience, and more information on drug interactions and adverse reactions.

Implications of a Federal Compendium

Take a hard look at the implications of a federal compendium. It would have the force of law, virtually dictating what drugs to use and how to use them. In effect, it would be a regulatory document with legal or quasi-legal status, posing medical/legal problems similar to those the doctor may now encounter if and when he departs from the provisions of the package insert. A compendium under federal aegis would tend to restrict decisions on drug therapy to one orthodox level—a most dangerous trend for medicine.

New Compendium—A Medical Option

I detect no ground swell of initiative or support whatsoever for a federal compendium—or, for that matter, for a new compendium of any type. A 1969 PMA survey conducted by Opinion Research Corporation found that only 15 per cent of those physicians interviewed felt a new compendium was needed. And a large majority did not favor the involvement of the federal government if one were to be created, preferring instead a nongovernmental consortium.

Even if we come to a time when the medical profession itself opts for a new kind of compendium, it should be handled and financed, ideally, outside both government and industry. Final review and editorial authority could be delegated, say, to specialty bodies and medical societies—but above all, *not* the government.

Surely the health care system in the United States has far more vital matters to consider than the extensive cost and effort that would have to go into the preparation and maintenance of a new, monolithic compendium, and especially one bearing the imprimatur of the federal government.

Opinion & Dialogue

What is your opinion, doctor? We would welcome your comments.

The Pharmaceutical
Manufacturers Association
1155 Fifteenth Street, N.W.
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What does man have in common with Samson?

Neither man nor the gorilla can synthesize vitamin C. Interestingly, the slow loris, a primate much further down the evolutionary scale, can convert L-1,4-gulonolactone to ascorbic acid in its liver and presumably does not require an exogenous source of ascorbic acid.

Because man can neither synthesize vitamin C nor store most of the water soluble vitamins, these nutrients must be replenished continuously in order to maintain normal tissue levels.

Generally, this is accomplished in his daily diet. But under conditions of illness, stress, in convalescence or following surgery, vitamin stores may be depleted or metabolic demands increased.

In such cases, Surbex-T may be indicated. Surbex-T restores the water-soluble vitamins with each tablet providing 500 mg. of vitamin C plus high potency B-complex.

ABBOTT

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With the means at hand to drastically reduce the number of deaths each year from uterine cancer, we have embarked on a nationwide, life-saving program. Its goal is a Pap test by 1976 for every woman 20 years or older to whom the test is applicable, and for younger women at risk. An ambitious program, doctor, and one which can only be realized with your help.

We are faced with these facts: only 53% of women over 20 have ever had a Pap test; only 20% get a Pap test periodically; each year about 43,000 new cases are diagnosed; this year 12,000 women in this country will die of uterine cancer. And about 75% of these deaths will result from cervical cancer—as you know, almost 100% curable when diagnosed early and treated promptly.

We hope to reach women in the target group not only with the message about the *vital* Pap test, but also with the urgency of including it in the *regular* health checkup. The mortality rate from uterine cancer could thus be dramatically curtailed.

Clearly action is called for. Coordinated action—involving the doctor, the patient, the American Cancer Society—a partnership for life.

a partnership for life

American Cancer Society

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The West Virginia Medical Journal

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Mid-Facial Fractures: Management and Results*

Ghassan A. Khalil, M. D.

Mid-facial fractures are seen frequently following high speed impacts and improper use of safety belts. Most of these injuries are the result of car or motorcycle accidents and a few are due to fights or falls. The following study represents a four-year experience using the same principles and techniques.

Classification

I have divided these injuries into four major groups:

1. Blow-out fracture of the orbit.
2. Tripod fracture of the xygoma with associated injuries to the maxilla and orbit.
3. LeFort fractures II and III.
4. Other complicated fractures.

I excluded the very common fracture of the nose. This is a frequent injury which should be treated correctly to prevent the late complications. This subject has been covered by many previous publications.[1] I also excluded all other fractures of the mid-face which showed no displacement, were asymptomatic and presented no local complications.

Diagnosis

The diagnosis was made on careful physical examination and special x-ray studies including tomograms when indicated.

Treatment

The treatment consisted of ice packs over the injured area, semi-Fowler position, antibiotic coverage when there was evidence of contamination or fracture of the base of the skull. Open reduction was performed within 72 hours of the injury under general or local anesthesia, depending on the other associated injuries.[2]

The Author

- **Ghassan A. Khalil, M. D., Plastic Surgeon, 1130 Market Street, Parkersburg, West Virginia.**

Study and Results

1. Blow-out fracture of the orbit: 9 cases (Table 1).

The age varied between 13 and 52 years.

The follow-up varied between 3 and 9 months.

Five required a silastic sheet implant (0.004" thick) because of a major loss of bone.

Four required only a gelfilm sheet to keep the reduced bone smooth under the inferior rectus muscle.

One required a Caldwell Luc antrotomy with packing because of unstable reduction.[3]

Two were associated with nasal fractures which required only closed reduction with application of cast.

One required a skin graft because of major loss of soft tissue.

The final results were considered good functionally and cosmetically in all cases. (Figures 1-2).

Tripod Fractures Of The Xygoma With Associated Injuries To Maxilla And Orbit

Ten cases (Table 2).

The age varied between 16 and 70 years.

The follow-up varied between 4 and 22 months.

*Delivered during the Annual Meeting of the West Virginia Chapter, American College of Surgeons, May 3-5, 1973, at The Greenbrier, White Sulphur Springs.

TABLE 1

	BLOW–OUT FRACTURES											
	Age	Side	Followup in Months	Wiring	Silastic Implants	Gelfilm Implants	Antral Packing	Intermaxillary Fixation	Nasal Plate	Type	Complications	Final Results
1.	36	L	6		+							G
2.	39	L	4		+							G
3.	13	L	8			+						G
4.	52	L	4			+						G
5.	13	R	4		+							G
6.	28	R	3		+							G
7.	26	L	9		+						Skin Graft	G
8.	27	R	5			+						G
9.	38	R	9			+						G

L—Left, R—Right, +—Present, G—Good, F—Fair

Seven required wiring because of unstable reduction.

Six required silastic sheet implants because of loss of bone in the orbital floor.

Three required gelfilm sheet implants to keep the reduced bone smooth under the inferior rectus muscle in the orbital floor.

Two required a Caldwell Luc antrotomy with packing because of severely comminuted fracture of the anterior wall of the maxilla.

One required closed reduction and cast application of an associated nasal fracture.

There were two complications:

One developed a hematoma which was evacuated.

One developed infection which responded

TABLE 2

	TRIPOD FRACTURES											
	Age	Side	Followup in Months	Wiring	Silastic Impts.	Gelfilm Impts.	Antral Packing	Intermaxillary Fixation	Nasal Plate	Type	Complications	Final Results
1.	16	L	4	+	+							G
2.	18	R	6				+					G
3.	19	L	4			+						G
4.	19	R	22	+	+							G
5.	32	L	6	+	+							G
6.	70	L	20		+						Hematoma	G
7.	21	L	4	+		+						G
8.	38	L	11	+	+							G
9.	24	L	7	+	+		+				Infection	G
10.	22	L	5	+		+						G

TABLE 3

	LeFort FRACTURES											
	Age	Side	Followup in Months	Wiring	Silastic Implant	Gelfilm Implant	Antral Packing	Intermaxillary Fixation	Nasal Plate	Type	Complications	Final Results
1.	62		16	+	+			+	+	II		G
2.	37		10	+	+			+	+	II		G
3.	43		8	+	+			+	+	III	Trache-ostomy	G
4.	35		12	+	+			+	+	II		G
5.	51		8	+	+			+	+	II		F
6.	53		12	+	+			+	+	III		G
7.	21		12	+		+		+	+	III		F

to antibiotic therapy.

The final results were considered good in all cases.

LeFort Fractures

Seven cases[4] (Table 3).

The age varied between 21 and 62 years.

The follow-up varied between 8 and 16 months.

Four belong to the LeFort II group.

Three belong to the LeFort III group.

All presented rhinorrhea.

The treatment of all cases consisted in:

Open reduction with wiring of all fractures.

Frontal suspension.

Intermaxillary fixation with arch bars.

TABLE 4

	OTHER COMPLICATED FRACTURES											
	Age	Side	Followup in Months	Wiring	Silastic Implant	Gelfilm Implant	Antral Packing	Intermaxillary Fixation	Nasal Plate	Type	Complications	Final Results
1.	62	R	6		+	+			+	+		G
2.	19	R	36		+	+			+	+	Enophtalmus & Diplopia	F
3.	22	R	4									G
4.	19	L	10		+					+		G
5.	27	R	6					+	+			G
6.	21	L	8		+	+				+		G
7.	23	R	12				+	+				G
8.	32	L	6		+		+					G
9.	22	R	5		+					+		G

Lead plates to maintain nasal fracture reduction.

Silastic implants in the orbital floor when bone loss is present.

One required a tracheostomy because of airway difficulty.

The late results were considered good in five and fair in two, only because of unsatisfactory cosmetic appearance. (Figures 3-4-5-6-7).

Other Complicated Fractures

Nine cases (Table 4).

These involved multiple facial bones and soft tissue:

All presented fracture of the maxilla and the orbit on one side of the face.

Two presented associated fractures of the mandible.

Five presented fractures of the naso-orbito-ethmoidal complex with rhinorrhea. (Figures 5-6, 8-9).

One presented associated fracture of the frontal sinus.

The age varied between 19 and 62 years.

The follow-up varied between four and 36 months.

Four required wiring because of unstable reduction.

Figure 1 (left). Direct impact on the left eye with laceration of the eyebrow which resulted in blow-out fracture of the orbital floor. Figure 2 (right). The same patient one year later. Good final result.

Figure 3 (left). Classical picture of LeFort III fracture following a car accident. Note the severe generalized swelling associated with dental malocclusion. Figure 4 (center). The same patient two weeks later. He still has the intermaxillary wiring and the frontal suspension. The nasal lead plate was removed. Figure 5 (right). The same patient one year later with good functional and cosmetic results.

Figure 6 (left). LeFort III fracture three days after a car accident. Note the severe depression of the right maxilla and orbital floor. Figure 7 (right). The same patient one year later. The patient is asymptomatic but the result was considered fair because of unsatisfactory cosmetic appearance with the right maxilla still depressed. The patient refused further corrective surgery.

Figure 8 (left). A severely depressed naso-ethmoido-orbital fracture with rhinorrhea. The injury was associated with partial avulsion of the right upper eyelid. Figure 9 (right). The same patient one year later with good final result.

Three required silastic sheet implants because of loss of bone in the orbital floor.

Two required gilfilm implants in the orbital floor.

Five required nasal plates to maintain nasal fracture reduction.

Two required a Caldwell Luc antrotomy with packing because of comminution and depression of maxillary fracture (Figures 10-11).

Three required intermaxillary fixation with arch bars because of dental malocclusion.

There was one late complication with enophthalmos and mild diplopia which required further corrective surgery with satisfactory result. All the others were considered good. (Figures 12-13).

Discussion

Aggressive treatment was used in all displaced and symptomatic cases of mid-facial fractures. The final results were considered good. The only major late complication was due to a very extensive and severe crash injury to one side of the face with loss of a large bony

Figure 10 (left). A severe comminuted fracture of the right maxilla, orbital floor, and nose. The patient required silicone implant in the orbital floor, antral packing through Caldwell Luc approach, and lead plate to maintain nasal fracture reduction. The picture was taken two days after surgery. Figure 11 (right). The same patient one year later. Good final result.

Figure 12 (left). Six months after massive injury to the right side of her face. Patient still has lack of bone in the area shown by arrows associated with mild enophthalmos and diplopia. Figure 13 (right). Final result two years later after multiple surgeries using bone graft and silicone implant.

structure. The other three minor complications (hematoma, infection, skin loss) were corrected satisfactorily by conventional methods.

In spite of the present controversy concerning the treatment of blow-out and some of facial fractures, I favor open reduction and exact restoration of the anatomy in all mid-facial fractures. Done with care and experience, the final results are very satisfactory. None of the usual complications mentioned in other publications were present in this study: dental malocclusion, severe late enophtalmus, and diplopia, depression and deformity of the bony structures, blindness, permanent anesthesia of the infraorbital nerve distribution (Figures 7-8-9).

Summary

Thirty-five cases of midfacial fractures were studied during a period of four years. The author favors open reduction and exact restoration of the anatomy because of good late results and rare complications.

A list of references may be obtained by writing The Journal.

Stroke Rehabilitation In The Community Hospital

Mary Frances Borgman, BSN, MEd., R. N.; and James V. Gainer, Jr., M. D.

There are approximately 4,500 stroke victims in West Virginia each year, of which 500 - 600 die from the initial stroke.[7] Even though some 4,000 patients survive the initial cerebrovascular insult, far too many of them become unnecessary victims of functional deficits, statistics of chronic disease, and dependent on their family or society.

Although the disabilities and problems resulting from a stroke cannot be minimized realistic stroke rehabilitation can help as many as 60 - 70 per cent[3] of surviving stroke patients. These patients can be very effectively cared for initially in community hospitals by their family physician, and later their rehabilitation continued at home. While a rehabilitation center is obviously better, very few of these facilities are available; and, home rehabilitation has the advantage of familiar surroundings.

The primary purpose of stroke rehabilitation is the correction of the discordant relationship between the patient and his environment. The correction is attained through a planned program to restore the patient to his maximal function by capitalizing on his abilities and by minimizing his disabilities. The stroke patient usually had had no time to prepare for the catastrophe which has occurred. His threat to life, helplessness and bewilderment are very stressful to him and to his family. The family will appeal to the physician not only for diagnostic and therapeutic assistance but also for understanding and acceptance.

The key to a successful rehabilitation plan is to begin early. Stroke rehabilitation is difficult if a patient is plagued by spastic paralysis, contractures, urinary incontinence and personality disintegration. Since the greatest hope is for the new stroke victim, the community hospital becomes the critical rehabilitative facility. The family physician and ancillary team members must develop realistic goals for each stroke patient. These goals include:

1. Prevention of deformities, contractures and decubiti.

2. Bowel and bladder retraining.

The Authors

- **Mary Frances Borgman, BSN, MEd., R. N., Assistant Professor, West Virginia University School of Nursing, Morgantown; and James V. Gainer, Jr., M. D., Chief Resident and Instructor in Neurosurgery, WVU School of Medicine.**

3. Independent performance of activities of daily living (ADL).

4. Independent mobilization and ambulation.

5. Maximal use of communication and language abilities.

6. Adaptation to personality, intellectual, and non-language deficits.

7. Family participation in the care plan.

Deformities, Contractures and Decubiti

Musculoskeletal and skin problems can be combated by three preventive approaches[1,5] which family members should also be taught to perform. This kind of family inclusion promotes understanding, acceptance and communication during the stroke crisis.

Positioning is a lost art and skill. The time, equipment and energy required, however, will be rewarded by attainment of a rehabilitation goal and reduced hospitalization stay and costs. During flaccidity and as spasticity appears a schedule of positioning is necessary to prevent the predictable hemiplegic deformities. The affected upper extremity is abducted and elevated on pillows so that the hand is higher than the shoulder in order to prevent edema. Handrolls are used to prevent hand contractures. External rotation of the hip is prevented by a trochanter roll. A properly utilized footboard helps to prevent footdrop. Great care must be exercised to avoid positions of continuous knee and hip flexion.

Good skin hygiene is imperative with the incontinent bed patient. Besides cleansing, the most important part of the skin care is observation. A reddened area is indicative of a cone of necrosis lying beneath it. The area is massaged and if blanching does not occur, the pa-

tient is re-positioned off the area until blanching does occur. Application of Tincture of Benzoin only complicates the problem because blanching cannot be evaluated; also foam doughnut shaped rings generally cause more vasoconstriction and further contribute to ulcer formation.

Passive range of motion of the non-affected side as well as the affected extremities begins after admission. Active range of motion is taught as soon as the patient is cooperative.

Bowel and Bladder

The hemiplegic bladder, an upper motor neuron bladder, is a reflex and uninhibited bladder and bladder retraining[1,8] can be instituted for most patients. Catheterization is usually for staff convenience rather than patient need. A few days of incontinence must be anticipated, but most new stroke patients *want* to become continent. Therefore, a specific and progressive q2h day and night bladder routine is initiated. The patient may need reminders as well as praise for successes. Incontinence patterns should be pointed out in a non-punitive way. Nocturnal problems are helped by decreased evening fluid intake, external devices and protective underwear. The longer bladder training is delayed the more difficult it becomes.

Bowel management[1,8] is attained by regulating diet, fluid and exercise. The program needs to be planned in regard to formal bowel habits, home facilities and the need for assistance in transfer and ambulation at home.

Activities of Daily Living (ADL)

Independent eating, dressing, toileting and grooming[1,2,5,6,8] can mean the difference between hope and despair, between being loved by the family and being a burden on the family. Unfortunately, the hospital routine often dictates that the personnel "do for the patient" instead of allowing the patient to "do for himself." According to the patient's readiness, the stroke victim is taught the principles of ADL; this gives the staff an excellent opportunity to promote communication patterns.

If there is no contraindication for the patient to be out of bed, meal time is an appropriate opportunity for a patient to be seated at a table. Selection of semi-moist food, instead of all liquids, and the placement of food on the non-affected side of the mouth adds to the palatability of food and the independency of eating. Dehydration and resulting confusion are prevented by the increased oral intake.

The non-affected extremity is actively employed during bathing and grooming. To help correct body image distortion, position the patient so he can see himself in a mirror during grooming. Even in community hospitals, independent dressing should be taught, performed and evaluated in order to prevent dependency at home.

Many ADL devices[2] are available; but generally, only a rocker knife, a long handled bathing sponge, and a suction brush are needed. A home evaluation of bathroom facilities is important for accurate ADL planning.

Balance, Transfer, and Ambulation

The patient who has had a thrombosis may begin mobilization activities in 24-48 hours.[4] With hemorrhagic and embolic strokes the state of consciousness and the nature of the underlying disease will determine the mobilization time. Specific bed and muscle strengthening exercises are taught and performed q2-4hours during the day in preparation for mobilization. Since hemiplegics should be pivoted instead of being carried or dragged into a chair, quadricep strength is evaluated for standing and transfer safety. If available, long leg braces for knee instability and short leg braces for ankle instability may add to early ambulation.

Every effort should be made to promote ambulation as soon as possible. A normal walking pattern should be encouraged as the slow and awkward hemiplegic gait is fatiguing. It can be anticipated that left hemiplegics with their proprioceptive problems will have more difficulty with ambulation.

Communication and Language

Receptive and expressive aphasia make any rehabilitation effort difficult but not impossible. In fact, an aphasic patient is easier to help than one who has difficulties with body image and proprioception. Although it is helpful to obtain a speech therapy consultation, this may not be feasible in community hospitals. The physician and nursing staff must ascertain and strengthen the remaining communication abilities of the patient.

Dysarthria, which may be improved by simple exercise, is often mistaken for aphasia. Automatic speech such as cursing, singing and reactive speech is not purposive speech; therefore, it can not be relied upon for validity. The automatic reply should never be a source of staff jokes. It must also be remembered that the pa-

tient is often more astute to conversation and body language of others than may be realized.

Personality, Intellectual and Non-Language Deficits

Problems such as agnosia, alexia, astercognosis, apraxia, and perservation[8] complicate communication. Homonymous hemianopsia[8] is another frequently identified problem. Unfortunately, too many times it goes unheeded and the rehabilitation goals fall apart because all the teaching has been performed from the visually defective side. The left hemiplegic may have spatial-perceptual deficits and be unable to recognize that side of his body. Nurses can devise many individual techniques to work with these deficits once they are identified.

Many stroke patients are quite labile emotionally, and will experience episodic crying or laughing. The patient usually is aware that his behavior is inappropriate; but he needs the realistic understanding and care of others to help him move beyond the situation. Learning impairments such as short attention span, loss of memory, and poor judgment make it necessary that rehabilitative teaching be from simple to complex, be repetitive, and be individualized in order to have a successful outcome.

Home and Community

The success of the stroke rehabilitation plan is really measured when the patient returns home and to the community. Ultimate defeat and dehabilitation will occur if the family has not been actively involved in the rehabilitation activities in the hospital. They need to know specifically what the patient can and cannot do so that the home life does not undergo major interruption or total disintegration.

After initial diagnosis and treatment during the acute phase of a stroke, the most important aspect is to initiate rehabilitation procedures. This should be done early, and may be done successfully in any hospital. A minimum amount of equipment and a maximum effort on the part of the physician and nurse are needed. An appraisal of the patient's neurologic deficits should be made and an individual program designed to enable the patient to overcome or work around them established. This program should include the family. Once learned, the basic principles of rehabilitative care of the stroke patient are not difficult.

A list of references may be obtained by writing The Journal.

Acupuncture and Deafness

FURTHER evidence that acupuncture cannot cure nerve deafness is presented in scientific reports in the June issue of *Archives of Otolaryngology,* a publication of the American Medical Association.

Because of a surge of popular interest in acupuncture as a cure for deafness and a flow of patients to half a dozen acupuncture centers in the District of Columbia, the District medical society asked a group of its members specializing in ear problems to evaluate the technique. The group reports on treatment of 123 ears of deaf or partially deaf patients who sought acupuncture, with the conclusion that "The data available in this study do not support the popularized notion that acupuncture cures deafness." More patients showed deterioration than improvement, they say. The Washington study is by David N. F. Fairbanks, M. D.; Ellis A. Wallenberg, M. S., and Blair Webb, M. D.

Another report in the same journal describes an effort to use acupuncture to cure deafness in a 63-year-old man in Chicago. Full measurements of hearing were made before and after treatment, and "There was no change in hearing level." This report is by Richard E. Mareus, M. D., and Robert A. Goldenberg, M. D. of the University of Illinois Eye and Ear Infirmary, Chicago.

X-Ray Case of the Month

Chronic Berylliosis

Murray B. Hunter, M. D., Fairmont; and Ray A. Harron, M. D., Bridgeport

Murray B. Hunter, M. D., Internist:

This is a 38-year-old female who has been followed for six years. Her complaints over the years have included slow healing skin ulcers, some type of "dermatitis" of the legs, "atypical lichen planus," backaches, pains in various joints of the four extremities at different times, fatigue, indigestion, dysparunia, shortness of breath, chest pain, and muscle tenderness. Various work-ups over the years were essentially negative except for the chest films.

Ray A. Harron, M.D., Radiologist:

Chest x-rays show fibronodular densities involving primarily the middle and upper lung fields, but to some extent the lower lung fields also. The nodules vary in size up to 3mm. Lymphadenophathy is not a prominent feature of this film. Differential diagnosis would include sarcoidosis and pneumoconiosis such as berylliosis.

Doctor Hunter:

Occupational history showed that the patient was working in a fluorescent light factory and 10 years ago was tapping fluorescent lights.

An open-chest biopsy of the right middle lobe was done and this confirmed the diagnosis of berylliosis.

This case represents a case of chronic berylliosis, an insidious disease which is characterized by a variety of complaints as illustrated by this patient and symptoms may not appear for up to 15 years after exposure to beryllium salts. The ore does not produce the disease which is seen only in refinery workers, alloy workers, and fluorescent light workers; but not in those who work with the ore.

Figure 1.

Integument!

Our skin—the human integument—covers us, defines us, protects us. But skin is subject to cuts, burns, abrasions. And infections. Neosporin Ointment fights infection by providing broad antibacterial action against susceptible skin invaders. It contains antibiotics that are rarely used systemically, reducing the risk of sensitization.

INDICATIONS: *Therapeutically*, used as an adjunct to appropriate systemic therapy for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection.

Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components.

PRECAUTION: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Complete literature available on request from Professional Services Dept. PML.

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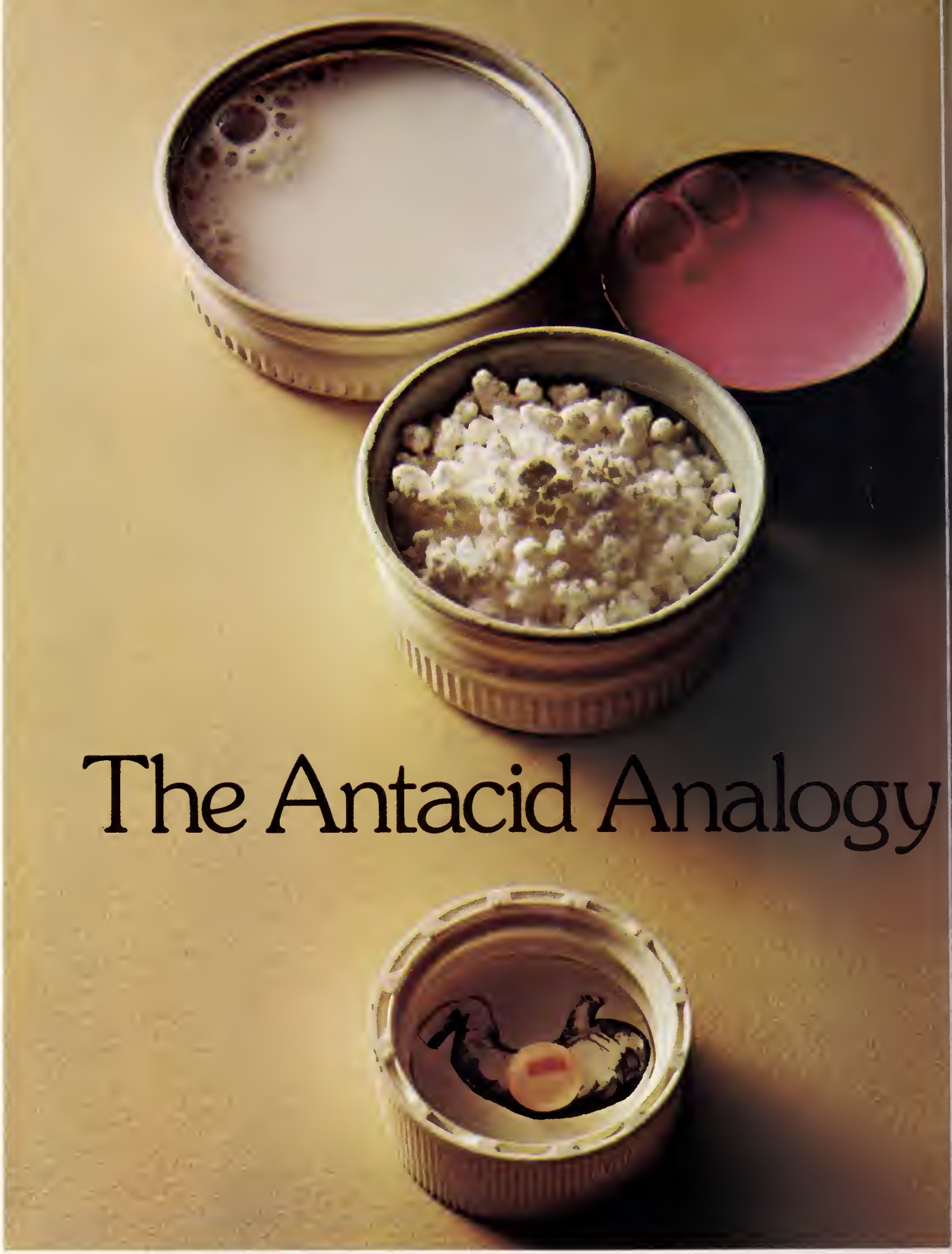

Indications: Pro-Banthine is effective as adjunctive therapy in the treatment of peptic ulcer. Dosage must be adjusted to the individual.

Contraindications: Glaucoma, obstructive disease of the gastrointestinal tract, obstructive uropathy, intestinal atony, toxic megacolon, hiatal hernia associated with reflux esophagitis, or unstable cardiovascular adjustment in acute hemorrhage.

Warnings: Patients with severe cardiac disease should be given this medication with caution.

Fever and possibly heat stroke may occur due to anhidrosis.

In theory a curare-like action may occur, with loss of voluntary muscle control. For such patients prompt and continuing artificial respiration should be applied until the drug effect has been exhausted.

Diarrhea in an ileostomy patient may indicate obstruction, and this possibility should be considered before administering Pro-Banthine.

Precautions: Since varying degrees of urinary hesitancy may be evidenced by elderly males with prostatic hypertrophy, such patients should be advised to micturate at the time of taking the medication.

Overdosage should be avoided in patients severely ill with ulcerative colitis.

Adverse Reactions: Varying degrees of drying of salivary secretions may

Therapeutic comparisons in peptic ulcer.

ntacids have only one mode of action to relieve ulcer pain...

Pro-Banthine® has four.

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ropantheline bromide

ntacids:

tacids relieve ulcer pain by neutralizing gastric d. This action is relatively short-lived and they have other mode of action.

o-Banthine:

o-Banthine suppresses gastric acid cretion. The antisecretory properties of o-Banthine are well established. By effectively ocking vagotonic impulses Pro-Banthine suppresses stric secretion to reduce both total and free acid.

o-Banthine helps relieve pain. o-Banthine relieves ulcer pain by reducing gastric cretion and the motility and spasm of the strointestinal tract.

Pro-Banthine reduces acidity without subsequent acid rebound. The capacity of Pro-Banthine to reduce the secretion of total and free acid in the stomach has been demonstrated in scores of studies. None has demonstrated any significant evidence of acid rebound.

Pro-Banthine activity lasts about six hours. The effect of a single therapeutic dose (15 mg.) of Pro-Banthine lasts about six hours.* Pro-Banthine P.A.®, the prolonged-acting form, is active from 8 to 12 hours. Thus Pro-Banthine may be used to suppress acid, spasm, and pain around the clock, even during the sleeping hours when antacids, to be effective, must be taken almost hourly.

*Innes, I. R., and Nickerson, M., in Goodman, L. S., and Gilman, A. (editors): The Pharmacological Basis of Therapeutics, ed. 4, New York, The Macmillan Company, 1970, p. 537.

Pro-Banthine complements and enhances the action of antacids.

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ur as well as mydriasis and blurred vision. In addition the following verse reactions have been reported: nervousness, drowsiness, dizziness, omnia, headache, loss of the sense of taste, nausea, vomiting, constipa-n, impotence and allergic dermatitis.

sage and Administration: The recommended daily dosage for adult l therapy is one 15-mg. tablet with meals and two at bedtime. Subse-ent adjustment to the patient's requirements and tolerance must be de.

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How Supplied: Pro-Banthine is supplied as tablets of 15 and 7.5 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg.

fore prescribing, see complete prescribing ormation in SK&F literature or *PDR*. The lowing is a brief summary.

lications: Edema associated with congestive art failure, cirrhosis of the liver, the nephrotic ndrome; steroid-induced and idiopathic ema; edema resistant to other diuretic therapy. so, mild to moderate hypertension.

ntraindications: Pre-existing elevated serum tassium. Hypersensitivity to either component. Continued use in progressive renal or patic dysfunction or developing hyperkalemia.

arnings: Do not use dietary potassium supplents or potassium salts unless hypokalemia velops or dietary potassium intake is markedly paired. Enteric-coated potassium salts may use small bowel stenosis with or without ceration. Hyperkalemia (>5.4 mEq/L) has en reported in 4% of patients under 60 years, 12% of patients over 60 years, and in less an 8% of patients overall. Rarely, cases have en associated with cardiac irregularities. cordingly, check serum potassium during erapy, particularly in patients with suspected confirmed renal insufficiency (e.g., elderly or abetics). If hyperkalemia develops, substitute hiazide alone. If spironolactone is used ncomitantly with 'Dyazide', check serum tassium frequently—both can cause potassium tention and sometimes hyperkalemia. Two aths have been reported in patients on such mbined therapy (in one, recommended sage was exceeded; in the other, serum electlytes were not properly monitored). Observe tients on 'Dyazide' regularly for possible ood dyscrasias, liver damage or other idiocratic reactions. Blood dyscrasias have been ported in patients receiving Dyrenium iamterene, SK&F). Rarely, leukopenia, rombocytopenia, agranulocytosis, and aplastic emia have been reported with the thiazides. atch for signs of impending coma in acutely cirrhotics. Thiazides are reported to cross the acental barrier and appear in breast milk. his may result in fetal or neonatal hyperbilibinemia, thrombocytopenia, altered carbodrate metabolism and possibly other adverse actions that have occurred in the adult. When sed during pregnancy or in women who might ear children, weigh potential benefits against ssible hazards to fetus.

ecautions: Do periodic serum electrolyte and UN determinations. Do periodic hematologic udies in cirrhotics with splenomegaly. Antipertensive effects may be enhanced in postmpathectomy patients. The following may cur: hyperuricemia and gout, reversible trogen retention, decreasing alkali reserve ith possible metabolic acidosis, hyperglycemia d glycosuria (diabetic insulin requirements ay be altered), digitalis intoxication (in ypokalemia). Use cautiously in surgical tients. Concomitant use with antihypertensive ents may result in an additive hypotensive fect.

dverse Reactions: Muscle cramps, weakness, zziness, headache, dry mouth; anaphylaxis; sh, urticaria, photosensitivity, purpura, other rmatological conditions; nausea and vomiting ay indicate electrolyte imbalance), diarrhea, nstipation, other gastrointestinal disturances. Rarely, necrotizing vasculitis, paresesias, icterus, pancreatitis, and xanthopsia ve occurred with thiazides alone.

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erum Potassium Level Drops During Long-Term xercise, *Medical Tribune*, July 4, 1973.
o implication that 'Dyazide' is useful in reventing K^+ loss in athletes is intended.

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107th ANNUAL MEETING

of the

West Virginia State Medical Association

The Greenbrier

AUGUST 21-24, 1974

PLAN NOW TO ATTEND

A message from . . .

The President

TOO GOOD TO MISS!

LAST September, in my initial message to you in this space, I told you that the 1974 Program Committee had already undertaken its task of planning the 107th Annual Meeting at The Greenbrier.

Take time to read the news article beginning on Page 167 and I'm sure you will agree they have arranged the program in a manner which will give us an opportunity to increase our knowledge by attending the scientific sessions—as well as ample time to relax and simply enjoy the wonderful atmosphere and recreational facilities at this world-famous hotel.

Other organizations—state, regional and national—have followed our lead and now meet regularly at The Greenbrier. We hope you won't pass up the opportunity to attend our meeting which is practically in your backyard.

Watch for the complete program in the August issue of *The Journal* and I feel sure you will make plans to join us at the Annual Meeting next month. If you've neglected to make a room reservation, don't waste time—call the Reservation Manager immediately.

Tom McCoy

A. THOMAS MCCOY, M. D., *President*

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Editor
GEORGE F. EVANS, M. D.
122 South Sixth St.
Clarksburg, W. Va.

Managing Editor and
Business Manager
MR. WILLIAM H. LIVELY
Box 1031
Charleston, W. Va. 25324

Associate Editors:
VERNON E. DUCKWALL, M. D.
Elkins
JOHN M. HARTMAN, M. D.
Charleston
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Wheeling

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EDITORIALS

EFFECT OF LOUD MUSIC ON HEARING

During the past decade or so more and more attention has been paid to the effect of noise on hearing. Not much scientific attention was given this matter earlier in this century, although it was known that loud noise such as is produced in a boiler-plate factory often produced deafness. It has been recognized recently, however, that any loud noise should be classified as an important pollution factor. In this essay the effect of loud music will be discussed briefly on hearing.

Late this past year the matter of music and noise was interestingly reviewed by by D. L. Chadwick (Proceed. Roy. Soc. Med., Nov., 1973). He points out that the borderline between noise and music is often slender and that danger is considered to exist when overall pressure exceeds 95 decibels (a unit of hearing—a decibel is the least intensity at which any given note may be heard).

It must be emphasized that some individuals are far more susceptible to noise than are others. The difficulty is that it cannot be predetermined who is unusually susceptible. There is good evidence that the female ear is more resistant to noise than the male. The extent and duration of exposure are, of course, important factors; the type of music is also significant. It seems almost incredible that bellringing less than one-half hour a week can result in permanent deafness in as little as 10 years. It is known that professional players of percussive instruments, especially members of jazz bands or large symphony orchestras are apt to become moderately hard of hearing. In this essay, however, the influence of loud music on the listener will be considered and not on the professional musician.

Symphony orchestra music is on the whole relatively safe to the listener and so far as it is known produces no permanent injury to hearing. Mostly the intensity of the music is somewhat less than 70 decibels which lies well within the safety range. There are times when the intensity may reach 99 decibels, but these periods do not last long. This is most gratifying because symphony music is an important cultural heritage; there are many fine symphony orchestras in our country and hosts of people attend orchestra concerts.

So-called "rock and roll music" presents a different picture. The highest level recorded for this type of music was 119 decibels, well above the safe range. It was concluded that prolonged exposure to rock and roll music might produce threshold shifts and permanent cochlear damage, especially in persons unusually susceptible to noise. It was pointed out that other factors, particularly the addition of amplified and reamplified reverberations which often accompany rock and roll music, enhance the damage to hearing. Unfortunately for their fu-

ture acuity many young people greatly enjoy rock and roll music. Whether permanent damage is actually produced by rock and roll music has been questioned, but there is solid experimental data which show that some animals exposed to this type of music suffered severe damage to the sensory cells of the cochlea.

The intensity of pop-music has also been studied. The consensus was that this type of music does not constitute a serious hazard to the occasional listener, but that habitual exposure could result in some hearing loss. This is a pity for many people, both young and old, take great pleasure in listening to pop music.

It is difficult to bring about changes to remedy the danger of permanent hearing loss caused by loud music, such as that produced by rock and roll. Young people are little interested in what may happen to their hearing in later life and are quite reluctant to forego a pleasure which appears to be innocent enough. The philosophy youth seems to adopt is that the louder the noise the more fun they can have. Fortunately in most instances the damage to hearing is not severe, and many are probably not aware of their hearing loss. This, however, is not always true. About all that can be done presently is to call attention to the danger of extremely loud noise to the hearing apparatus. It is possible that rock and roll music will become less popular for the new generation. In any event, something may be worked out to remedy the situation. In the meantime it is to be hoped that not too many young people will suffer severe hearing loss.

AMA JOINS FIGHT AGAINST FORCED RETIREMENT

The American Medical Association will join in a suit to declare unconstitutional a federal law requiring mandatory retirement of U. S. Civil Service employees at a particular age, the AMA has announced.

The AMA Board of Trustees, noting the Association's long-established position against chronological age as a basis for mandatory retirement, approved AMA participation as amicus curiae in the litigation. The plaintiff is a 70-year-old attorney who the government acknowledges is above average in competence and physically capable of performing the duties of the position.

The AMA expressed its firm opinion that "workers who are capable and who personally desire to postpone retirement should be encouraged to do so by adoption of flexible retirement policies by both industry and government. Biological age, not chronological age, should be used in deciding when a man should retire."

Retirement at a fixed age carries with it multiple physical, emotional, social and financial ramifications, the AMA declared. Compulsory retirement, without regard for the individual's desire and ability to continue work, can be a prime factor in health deterioration of the retiree.

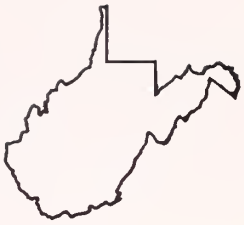
"Considerable medical evidence is available to indicate that the sudden cessation of productive work and earning power of an individual, caused by compulsory retirement at the chronological age of 65, often leads to physical and emotional illness and premature death," the AMA Board declared.

The promotion of work opportunities for persons over 65 improves their life expectancy, physical and emotional well being, and their earning power, and reduces their dependence on family and government, the AMA said.

Plaintiff in the suit is Martin O. Weisbrod of the Chicago office of the Department of Housing and Urban Development (HUD). The case is scheduled this spring in a federal district court in Washington, D. C. The suit seeks to enjoin the Secretary of HUD and the Civil Service Commission from enforcing a provision of the U. S. Code which would force Weisbrod to retire on account of age. He seeks a declaratory judgment that the code provision is unconstitutional and requiring the government to continue his regular Civil Service employment until he voluntarily retires, is incapable of performing his assigned duties, or otherwise furnishes the Government with a valid cause to discharge him.

The AMA cited a recent report by the Gerontological Society saying: "Useful working life is being prolonged. Capable workers should be allowed to work if they so desire, even beyond the usual retirement age. Workers between 60 and 75 years of age are not only proving to be capable of working in many occupations; they actually excel younger persons because of their superior judgment, experience and safety of performance. Advances in technology that have taken away much of the physical stress of work tend in many instances to place a premium on the abilities that many older workers possess."

GENERAL NEWS



Senator Byrd and Doctor Todd To Speak At Annual Meeting

Plans have been completed for the 107th Annual Meeting of the West Virginia State Medical Association which will be held at The Greenbrier in White Sulphur Springs, August 21-24.

The Program Committee announced the names of two additional speakers who will present papers during the three general scientific sessions on Thursday, Friday and Saturday mornings, August 22-24.

Sen. Robert C. Byrd

Malcolm C. Todd, M. D.

Dr. J. Hugh Wiley of Morgantown, the Chairman, said that Dr. Louis Weinstein of Boston and Dr. Robert Veltri of the WVU School of Medicine will be among the participants in a "Symposium on Newer Concepts in Infectious Diseases" at the first general scientific session on Thursday morning, August 22.

Sen. Byrd and Dr. Todd Honor Guests

It was announced previously in *The Journal* that Sen. Robert C. Byrd of West Virginia, Majority Whip of the United States Senate, will deliver the "Thomas L. Harris Address" at the opening of the first general scientific session on Thursday morning, August 22.

Also, Dr. Malcolm C. Todd of Long Beach, California, who was installed as President of the American Medical Association during the Annual Meeting in Chicago last month, will speak at the first session of the House of Delegates on Wednesday afternoon, August 21.

First General Scientific Session

Dr. Philip M. Sprinkle of Morgantown, a member of the Program Committee, will serve as Moderator for the "Symposium on Newer Concepts in Infectious Diseases" on Thursday morning. The participants and their subjects will be as follows:

Louis Weinstein, M. D., Chief, Division of Infectious Diseases and Professor of Medicine, Tufts University School of Medicine, Boston. Subject: "Effects of Antibiotics on Changing Spectrum of Infection."

Charles H. Kirkpatrick, M. D., National Institute of Allergy and Infectious Diseases, Bethesda, Maryland. Subject: "Immunotherapy of Chronic Infectious Diseases."

Virgil M. Howie, M. D., Pediatrician, Huntsville, Alabama. Subject: "Acute Otitis Media."

Doctor Sprinkle also said that Dr. Robert W. Veltri, Associate Professor of Microbiology and Otolaryngology at the WVU School of Medicine, would assist him in making preliminary remarks to open the Thursday morning session.

Second General Scientific Session

The speakers at the second general scientific session on Friday morning will be as follows:

James F. Glenn, M. D., Professor and Chief of the Division of Urologic Surgery, Duke University Medical Center, Durham, North Carolina. Subject: "Surgical Causes of Hypertension."

Allen H. Mackenzie, M. D., Staff Member of the Division of Medicine — Department of Rheumatic Disease — Cleveland Clinic Foundation, Cleveland. Subject: "Diagnosis of Arthritis and Rheumatism in Children."

Robert F. Schilling, M. D., Washburn Professor of Medicine, University of Wisconsin Medical School, Madison. Subject: "The Logical Approach to Anemia."

Third General Scientific Session

The first portion of the Saturday morning program will be devoted to a discussion of the development and future plans for the Department of Family Practice at the WVU School of Medicine.

The speaker will be Dr. John W. Traubert, Chairman of the Department.

Doctor Wiley and the members of the Program Committee have set aside the remainder of Saturday morning's program to a discussion on "What Are the Barriers to an Improved Medical Practice in the State of West Virginia."

He said that the floor would be open for discussion of all questions that physicians in the audience be-

lieve need to be answered. It is anticipated that PSRO, malpractice insurance and other timely topics will be on the agenda. Doctor Wiley has again requested that members of the Association send along to him in advance of the meeting additional subjects they would like to have placed on the agenda.

Meetings of Sections and Affiliated Societies

An innovation at this year's convention will be breakfast meetings of section and affiliated societies of the Association. Many of the guest speakers have accepted invitations to present talks at the breakfast meetings.

Doctor Wiley indicated that the Committee requested that the section meetings be held in the morning to enable physicians and members of their families to enjoy the recreational facilities at The Greenbrier during the afternoon hours. There will be golf and tennis tournaments and plans are being worked out for a skeet shooting tournament.

Only the West Virginia Chapter of the American Academy of Pediatrics has elected to hold its meeting during the afternoon hours. The meeting will be held on Friday afternoon and the speaker will be Dr. Virgil M. Howie of Huntsville, Alabama.

Business Meetings

The Pre-Convention Meeting of the Council will be held on Wednesday morning and Doctor Todd will speak at the first session of the House of Delegates that afternoon.

Dr. A. Thomas McCoy of Charleston will deliver his Presidential Address at the final session of the House of Delegates on Saturday afternoon, August 24.

Room Reservations Pass 500 Mark

Reservations for the 107th Annual Meeting have passed the 500 mark as this issue of *The Journal* went to press. Physicians who plan to attend are urged to make reservations as soon as possible in order to be assured of accommodations at The Greenbrier.

The complete scientific program and other scheduled functions during the Annual Meeting will be published in the August issue of *The Journal.*

Dr. Philip M. Sprinkle Elected To National Specialty Board

Dr. Philip M. Sprinkle of Morgantown has been elected to a three-year term on the Board of the American Academy of Facial Plastic and Reconstructive Surgery, Inc. Doctor Sprinkle is Professor of Surgery and Chairman of the Division of Otolaryngology at the West Virginia University School of Medicine.

A Past President of the West Virginia Academy of Ophthalmology and Otolaryngology, he was elected during the national Academy's Annual Scientific Meeting held recently in Palm Beach, Florida. Dr. Trent W. Smith of Columbus, Ohio was elected President.

Dr. Carl B. Hall's Candidacy Endosed By Council

Dr. Carl B. Hall's candidacy for President Elect of the American Academy of Family Physicians was officially endorsed by the Council of the West Virginia State Medical Association during the Spring Meeting which was held at the Heart-O-Town Motor Inn in Charleston on June 9.

Carl B. Hall, M. D.

Doctor Hall, who has practiced medicine in Charleston since 1946, is currently serving as Chairman of the Board of Directors of the AAFP. The election will be held during the Annual Meeting of the Academy in Los Angeles, October 14-17.

Members of the Council were urged to enlist the support of their colleagues throughout the State in backing Doctor Hall's bid for the high national office in the Academy which has approximately 35,000 members.

New AMA Field Representative

Dr. Worthy W. McKinney of Beckley, Chairman of the Council, introduced Mr. Guy D. Beaumont, Jr., who was named recently as the new AMA Field Representative for the State Medical Association. He succeeds Mr. James S. Imboden, who recently accepted appointment as Executive Secretary of the Academy of Medicine of Columbus and Franklin County in Ohio.

Mr. Beaumont, whose office is in Columbus, also will serve as Field Representative for the Ohio, Virginia and Michigan medical associations.

Report on Medical Examiner's System

It was reported that Governor Moore's office had officially announced recently that funds to implement the Medical Examiner's System in West Virginia had become available and that the program should be placed in operation later this year.

It was pointed out that the State had received a $190,000 Federal grant from the Law Enforcement Assistance Administration, and this amount combined with the $150,000 in State funds should be adequate to initiate the program.

Also, it was reported that Governor Moore was expected to announce the names of six individuals to serve on the Commission on Postmortem Examinations which will oversee the program.

Meeting with Hospital Administrators

Dr. William E. Gilmore, Chairman of the Ad Hoc Liaison Committee named to meet with officers of the West Virginia Hospital Association, reported

briefly on the initial meeting which was held in Parkersburg on June 6.

Also representing the Association at the meeting were Drs. George R. Callender, Jr., of Charleston, and Richard C. Starr of Beckley; and Mr. William H. Lively and Charles R. Lewis of the headquarters staff.

Doctor Gilmore said the primary purpose of the Liaison Committee was to establish a better dialogue and rapport between practicing physicians and hospital administrators. He said it is hoped that the Committee will meet several times a year to discuss and act upon matters of mutual concern to both physicians and hospitals throughout the State.

Doctor Barber Named Honorary Member

The Council unanimously elected Dr. Daniel N. Barber of Charleston to honorary membership in the State Medical Association.

Doctor Barber, who recently retired from the practice of medicine, has been active in organized medicine for many years and served as Treasurer of the State Medical Association from 1958 to 1965.

Action on AMA Resolutions

It was reported that several resolutions would be introduced during the Annual Meeting of the American Medical Association in Chicago which would affect the membership of the AMA Council on Medical Education.

It was reported that the Parkersburg Academy of Medicine had officially asked the Council to instruct the two West Virginia Delegates to the AMA House of Delegates to support the resolutions which would amend the By-Laws so that the Council on Medical Education would consist of 11 active members, of whom not fewer than one nor more than five shall be full-time members of a medical school faculty.

The Council voted to endorse the resolution of the Parkersburg Academy of Medicine and instructed the West Virginia Delegates to support the resolution at the meeting in Chicago.

New System for Collection of Health Statistics

It was announced that the State Department of Health had been designated as the lead state agency in the development of a Cooperative Health Statistics System in West Virginia.

Dr. N. H. Dyer, State Director of Health, reported that a coordinating committee had been appointed to administer the System and in addition to himself, the other members are Dr. Harry A. Stansbury, Jr., State Director of Comprehensive Health Planning, Dr. Mildred Mitchell-Bateman, Director of the Department of Mental Health, and Mr. Edwin F. Flowers, Director of the Department of Welfare.

He said that all health data collected will be available to others for planning purposes and that all agencies in the State, public and private, will be informed as to what health data are being collected and in what form—thereby eliminating needless duplication and non-uniformity.

New Workmen's Compensation Commissioner

Dr. Kenneth C. MacDonald, Part-Time Director of Medical Services for the Workmen's Compensation Fund, announced that Governor Moore had appointed Mr. B. Frederick Becker as Commissioner of that agency during the past week. He said that Mr. Becker had been employed for the past five months as Assistant Tax Commissioner before being named to his new position.

The Council recommended that the Chairman of the Medical Economics Committee make an effort to arrange a meeting between Mr. Becker and members of the Sub-Committee on Workmen's Compensation at an early date.

Crippled Children's Legislation

Doctor Callender reported that the Legislature had passed a bill to reorganize the aid to Crippled Children's program on May 24, the final day of the special session of the Legislature called by the Governor.

He outlined the major revisions in the law—including the appointment of six physicians and one podiatrist to serve on an advisory board to assist the Director of the Department of Welfare with respect to the plans, policies and methods for carrying out the activities of the Department in re aid to Crippled Children.

(Subsequently, the bill was vetoed by Gov. Arch A. Moore, Jr. In his veto message, the Governor said the bill would have forced the State to forfeit $15.3 million in Federal money and there were technical and legal questions raised as to whether all insurance companies would be relieved of all their obligations to handicapped children).

Resolutions for Annual Meeting

The Executive Secretary reported receipt of resolutions from several county medical societies for introduction during the Annual Meeting at The Greenbrier. He said that only rough drafts of the resolutions had been received and that final versions of the resolutions would be prepared in time for presentation at the first session of the House of Delegates in August.

West Virginia Medical Institute

Dr. Harry S. Weeks, Jr., President of the West Virginia Medical Institute, Inc., and the Executive Director, Mr. Charles R. Lewis, presented a brief report on the recent activities of the Institute. A meeting of the Board of Trustees of the Institute was held following the Council meeting and a report of the proceedings of that meeting may be found elswhere in this issue of *The Journal*.

The meeting was attended by Dr. Worthy W. McKinney of Beckley, Chairman; Dr. A. Thomas McCoy of Charleston, President; Dr. William E. Gilmore of Parkersburg, President Elect; Dr. Jack Leckie of Huntington, Vice President; Dr. Kenneth C. MacDonald

of Charleston, Treasurer; Dr. Harry S. Weeks, Jr., of Wheeling, Councilor at Large; Dr. George R. Callender, Jr., of Charleston, Junior Councilor; Drs. Robert R. Weiler of Wheeling; Charles E. Andrews of Morgantown; Robert D. Hess of Bridgeport; Louis W. Groves, Jr., of Richwood; Harold N. Kagan of Huntington; J. L. Mangus of Charleston; and John J. Mahood of Bluefield; Mr. William H. Lively of Charleston, Executive Secretary; Mr. Custer B. Holliday of Charleston, Executive Assistant; and Mr. Charles R. Lewis of Charleston, Special Projects Director.

Also attending the meeting were Dr. Frank J. Holroyd of Princeton, AMA Delegate; Dr. N. H. Dyer, Director of the State Health Department; Dr. Mildred Mitchell-Bateman, Director of the State Mental Health Department; and Mr. Guy D. Beaumont, Jr., of Columbus, Ohio, AMA Field Representative.

Medical Institute Negotiates PSRO Planning Contract

The West Virginia Medical Institute, Inc., has negotiated a $48,000 federal contract to complete planning toward possible designation as the Professional Standards Review Organization (PSRO) in the state.

Dr. Harry S. Weeks, Jr., of Wheeling, the Institute's President, brought the State Medical Association's Council up to date on his organization's activities at a June 9 meeting in Charleston.

He told Council that the Institute's voluntary membership had grown to 808 doctors of medicine and osteopathy licensed and practicing in the state, or about 45 per cent of the total such physician population.

The Institute's own officers and trustees then met following the Council session and:

—Reviewed in further detail the planning contract with the U. S. Department of Health, Education and Welfare, and the scope of work to be completed under its provisions in the ensuing four to six months.

—Voted to hold in abeyance a decision as to exactly when the Institute might seek a subsequent contract for designation as West Virginia's conditional PSRO for a two-year period, pending receipt from federal authorities of additional PSRO guideline material and a definite schedule for acceptance of further contract proposals.

—Approved final negotiations with the Blue Cross Hospital Service, Inc., and Blue Shield of Southern West Virginia, Inc., on a contract for certain professional services to be provided by the Institute.

—Approved West Virginia Workmen's Compensation Fund coverage, as required by a 1974 legislative enactment, for Institute staff personnel; and also voluntary coverage for staff members under the state's unemployment compensation program.

—Approved development, with funds available to the Institute through the West Virginia Medical Program and West Virginia University, of a program to help interested hospitals upgrade medical records systems.

—Reviewed Institute activity in continuing medical education, including an in-progress final evaluation of the experimental Medical Association-RMP Voluntary Office Self-Audit Service (VOSAS) education project to be presented to the Medical Association's Committee on Medical Education and Hospitals on July 14.

—Also received an update on Institute consultation and staff training, as requested by the hospital's representatives, in development of a medical audit program at St. Mary's Hospital in Huntington—and also preliminary testing at St. Mary's of basic components of a proposed PSRO pilot mechanism.

The contract proposal to the Institute from the Southern West Virginia Blue Plans calls for (1) approval by West Virginia physicians, as an Institute function, of criteria, including length of stay the Blues are using in a professional review program covering private-pay admissions they cover in 44 hospitals and nursing homes; and (2) physician review, through the Institute, of those cases which fail two levels of staff screening within the Blues' own operations.

Doctor A. S. Daniel Elected President Of ACS Chapter

Dr. Angelo S. Daniel of Wheeling was elected President of the West Virginia Chapter of American College of Surgeons at its Annual Meeting held recently at The Greenbrier.

Other officers elected for 1974-75 included Drs. William E. Gilmore, Parkersburg, Governor; William E. Lawton, Jr., Charleston, First Vice President; Alfred D. Ghaphery, Wheeling, Second Vice President, Alvin L. Watne, Morgantown, Secretary-Treasurer, and F. Lloyd Blair, Parkersburg, member of the Council.

New officers of the West Virginia Chapter of American College of Surgeons are, from left, Dr. William E. Gilmore, Parkersburg, Governor; Alfred D. Ghaphery, Wheeling, Second Vice President; James P. Thomas, Bluefield, Immediate Past President; Angelo S. Daniel, Wheeling, President, and Alvin L. Watne, Morgantown, Secretary-Treasurer. Not shown are Drs. William E. Lawton, Jr., Charleston, elected First Vice-President, and F. Lloyd Blair, Parkersburg, member of the Council.

Doctor McCoy Delivers Address At Public Health Meeting

Dr. A. Thomas McCoy, President of the West Virginia State Medical Association, speaking before the West Virginia Public Health Association at its 50th Anniversary Meeting at Oglebay Park in Wheeling, said one of the prime needs in medical care today is catastrophic insurance coverage for the middle class American.

Doctor McCoy, who said he was speaking only for himself and not the Association, said, "hospital care is expensive and becoming more expensive every day. A serious illness can wipe out a family overnight with its expenses for treatment and care. Only the very rich or very poor can survive under the present system, and the middle American must be protected."

He also said that a definition for medical catastrophy was needed as well as a formula for handling it. He said, "without these things the cost of paperwork alone will cause the collapse of the system."

In his speech before about 300 persons in public health from around the State, Doctor McCoy also called for a state uniform land use act.

He said, "we still have precious, wonderful land in this State, and we need this act to protect that land and those people who occupy it."

He pointed out that the land is being exploited, and people who are living downstream from land and water that is being polluted are being exploited by the action of some who have no concern for land and other people.

Doctor McCoy also asked for more paramedic education and said, "there will never be a physician in every mountain community. It is an impossibility to dream of one on every corner, but people can be trained to care for many things. I would like to see some health education in the schools where students could be taught how to take blood pressures and learn some small but important things like making a bed with a patient in it. Just knowing things like this could shorten hospital stays."

During the annual meeting the public health people in attendance heard Sen. Jennings Randolph predict there would be some sort of national health insurance approved within two years, and T. L. Senn, Ph.D., Chairman of the Department of Horticulture at Clemson University discuss the ways horticulture was being used to assist the retarded, the handicapped, the blind, the alcoholic and the drug addict, and the prison inmate in South Carolina.

The group elected Jane L. Johnson, a secretary with the Southern West Virginia Regional Health Council, as President for the coming year. Dr. N. Allen Dyer, of the Council, was the retiring President.

Other officers elected include Mary Ann Flaherty, R. N., as President Elect; Richard Clelland, Vice President; and Earl Kurre, Treasurer. Greta Pridemore serves as Executive Secretary.

Change of Address

Members of the West Virginia State Medical Association are requested to notify the headquarters offices promptly concerning any change in address. Notices should be mailed to Box 1031, Charleston, West Virginia 25324.

Guests of honor of the Woman's Auxiliary to the Monongalia County Medical Society this past spring were wives of interns and residents of West Virginia University Hospital. The guests, all members of the House Staff Wives Club, are, from left, Mrs. F. Anthony Greco, Mrs. Roger Untalan, Mrs. Mark Roller, Mrs. R. Brooks Gainer and Mrs. Gary Marcus.

AMA President Is Guest of Family Physicians At Weirton Hospital

Dr. Russell B. Roth, President of the American Medical Association, was guest speaker at the annual Family Physicians Recognition Dinner held in May by the Department of Family Practice at Weirton General Hospital.

Dr. Thomas J. Beynon, Chairman of the hospital's Department of Family Practice, presided as toastmaster and general chairman. He was assisted by Dr. Ray S. Greco, President of the hospital's medical and dental staffs, and Dr. Richard E. Flood, a West Virginia State Medical Association Delegate to the AMA.

Two awards were presented by Dr. Eli J. Weller and Dr. Myer Bogarad, senior members of the family physicians group at Weirton General. Doctor Bogarad presented a plaque to Dr. Clark K. Sleeth, Professor of Medicine at West Virginia University and former Dean of the School of Medicine. Doctor Bogarad cited Doctor Sleeth's record in helping establish the four-year medical school at WVU and his preliminary work in establishing the Department of Family Practice at WVU last year.

Doctor Weller presented Mrs. Paul Morgan, President of the Hancock-Brooke Mental Health Society, a plaque for that organization's "outstanding contributions to mental health."

An honorary Associate Degree in Science was conferred on Doctor Roth by Dr. Daniel Crowder, President of the West Virginia Northern Community College.

Monongalia Auxiliary Is Striving To Keep Medical Grads In State

The Woman's Auxiliary to the Monongalia Medical Society is making an effort to induce graduates from the West Virginia University School of Medicine to remain in the State after graduation to practice medicine (See picture on Page 171).

In the fall, the Caduceanns, wives of students at the medical school, and their husbands, join the members of the Auxiliary and their husbands for a covered dish dinner.

In the spring, the Auxiliary entertains the wives of interns and residents at an evening dessert meeting. William L. Wylie, Assistant Professor of Forestry at WVU, presented a slide-lecture on "A Tour of West Virginia" this past spring.

"At these two meetings our aim is to become acquainted with our guests, to provide an interesting evening for them, and in every way possible to help promote the idea that West Virginia is a good State in which to have their husbands set up practice. Throughout the year, we continue to keep in touch with the members of these two groups," said Mrs. W. Merle Warman, Press and Publicity Chairman for the Auxiliary.

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled in the coming months.

1974

July 10—Breast Feeding Sem., Chicago.
July 14-20—Radiation Research Soc., Seattle.
July 25-27—Am. Electroencephalographic Soc., Seattle.
July 28-Aug. 1—Natl. Med. Assn., N. Orleans.
July 28-Aug. 2—Int. Assn. Child Psychiatry & Allied Professions, Phila.

Aug. 2-4—International Doctors in AA, O'Hare Airport (Inn).
Aug. 12-15—Am. Hosp. Assn., Chicago.

Aug. 21-24—107th Annual Meeting, W. Va. State Medical Assn., White Sulphur Springs.

Sept. 4-7—Am. Assn. Ob.-Gyn., Hot Springs, Va.
Sept. 5-7—Tri-State Otolaryngology Meeting, Sea Island, Ga.
Sept. 9-11—AMA Congress Occupat. Health, Chicago.
Sept. 16-19—Ky. Med. Assn., Louisville.
Sept. 18-20—Int. Symp. Epidemiology of Hypertension, Chicago.
Sept. 18-21—Am. Thyroid Assn., St. Louis.
Sept. 20-21—Symp. on Neonatology, El Paso.
Sept. 24-26—Kentucky Medical, Louisville.
Sept. 24-27—Am. Roentgen Ray Soc., San Francisco
Sept. 27-28—Am. Heart Assn., W. Va. Affiliate, Annual Meeting & Scientific, Wheeling.
Sept. 27-Oct. 2—Internat. Coll. of Surgeons, Portland.

Oct. 5-8—Am. Assn. of Ophthalmology, Dallas.
Oct. 6-10—Am. Acad. Oph. & Otol., Dallas.
Oct. 14-17—AAFP, L. A.
Oct. 16-18—Am. Cancer Society, New York.
Oct. 17-19—Am. Assn. for Surgery of Trauma, Hot Springs, Va.
Oct. 19-24—Am. Acad. Pediatrics, San Fran.
Oct. 20-22—Am. Coll. Preventive Med., N. Orleans.
Oct. 21-25—ACS Clinical, Miami Beach.
Oct. 21-26—Am. Coll. Gastroent., Bal Harbour, Fla.
Oct. 23-26—Pa. Medical Soc. Scientific, Harrisburg.
Oct. 24-27—Am. Acad. Child Psychiatry, San Fran.
Oct. 29-30—Am. Assn. Study of Liver Diseases, Chicago.

Nov. 1-3—Med. Soc. of D. C., White Sul. Springs.
Nov. 3-6—Med. Soc. Va., Williamsburg.
Nov. 6-9—Am. Soc. Cytology, N. Y. City.
Nov. 14-16—W. Va. Chap., ACS, Morgantown.
Nov. 17-20—Southern Med Assn., Atlanta.
Nov. 30-Dec. 4—AMA Clinical, Portland.

1975

Jan. 24-26—8th Annual Mid-Winter Clinical Conf., Charleston.

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WVU Medical Center –News–

• **Compiled from material furnished by Mrs. Mary Ellin Wylie, Director, Medical Center News and Information Services, Morgantown, W. Va.**

TWENTY-ONE students and three faculty members received special recognition recently at the West Virginia University School of Medicine's annual Awards Convocation.

The event honored student and faculty achievement through announcement and presentation of specific awards which have been established at the school by various donors.

Lange Book Awards for high scholastic achievement, given to two members of each class, went to M. Bruce Vukoson of Morgantown and David H. Johe of South Charleston, first-year students; Thomas A. Csencsitz of Morgantown and Gregory Mitchell of Charleston, second-year students; Charles J. Mirabile of Princeton and Joe N. Jarrett, Jr. of Oak Hill, third-year; and Ronald C. Hill of Parkersburg and Larry B. Wilshire of Chelyan, seniors. For their scholarship, Hill and Wilshire also received the Merck Manual Awards given to two members of the graduating class.

For outstanding scholastic achievement the Roche Award, a scroll and engraved watch, was presented to the member of the second-year class with the highest academic average, William D. Strauch of Wheeling.

Scholarship also brought Mosby Book Awards to five members of the second-year class: Marcia A. Bohn of Princeton, John N. Casto of Great Cacapon, Malcolm B. Louden, Jr. of Parkersburg, Margaret L. Simpson of Beckley and Andrew Summers of Glenville. Miss Simpson also won third place for her presentation at the Student Research Convocation.

The West Virginia University School of Medicine's recent annual Awards Convocation included the E. J. VanLiere Award, an engraved gold medal and check for $100, for Student Research Convocation presentation judged most excellent by a faculty-student committee. The award went to Howard L. Shackelford (right), a second-year student from Wheeling. At left is third place winner Margaret L. Simpson, a second-year student from Beckley. Miss Simpson also was one of five members of the second-year class to receive the Mosby Book Award.

The Upjohn Award, an engraved plaque and a check for $150, was received by Richard D. Lindsay of Martinsburg, President of the senior class. Based on applied personal qualities of character and leadership, the award is decided by class vote.

Recipient of the Lindsay Memorial Award, for outstanding performance in medical physiology by a first-year student, was David J. Larkin of Princeton. Donor of the ophthalmoscope-otoscope set in memory of his parents is Hugh Lindsay, Ph.D., who is a WVU professor of physiology and biophysics, currently on leave of absence, and a member of the School of Medicine Class of 1974.

The E. J. VanLiere Award, an engraved medal and check for $100, was received by Howard L. Shackelford of Wheeling, a second-year student. His presentation at the Student Research Convocation was judged by a faculty committee to be most excellent.

The Edward G. Stuart Memorial Award, honoring the late vice-president for WVU Medical Center, went to Joan P. Donley of Wellsburg. The award — an inscribed desk clock, a check, and the recipient's name engraved on a permanent wall plaque — is decided by a committee of School of Medicine department heads and is given to the fourth-year student who "best exemplifies the qualities of empathy and understanding and strengthens competency with compassion." The American Medical Women's Association Citation was also received by Mrs. Donley and two other fourth-year students, Polley H. Cunningham of Beckley and Claudia A. Goodwin of Morgantown.

For "demonstrated unusual teaching ability and a sincere interest in the progress of the entire class," the second-year class presented the MacLachlan Award, provided by the School of Medicine Alumni Association, to basic sciences faculty members Dr. Irvin S. Snyder, Professor and Chairman of Microbiology, and Dr. Stephen W. Carmichael, Assistant Professor of Anatomy. They received engraved desk plaques.

Named outstanding clinician for 1974 was Dr. Albert S. Klainer, Professor of Medicine and Chairman of Infectious Diseases. He was chosen by vote of the senior class and received an engraved silver plate.

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The Month in Washington

• **From the Washington Office of the American Medical Association.**

WITH the exception of a possible last-minute catastrophic bill to the liking of both the Senate and the House, the prospects for a national health insurance (NHI) bill this year appear to be fading. Preoccupied with the possible impeachment, plus other matters, the pace of House and Senate hearings on NHI has definitely slowed, despite a strong desire on the part of both Republicans and Democrats to take a widely popular health measure with them to the polls this November.

Its late April testimony on NHI before the House Ways and Means Committee behind it, the American Medical Association again advanced its Medicredit proposal for NHI before the Senate Finance Committee at the end of May.

Senate Finance Committee Chairman Russell Long, (D-La.), and other committee members heard AMA President Russell Roth, M. D., President Elect Malcolm Todd, M. D., and Ernest Livingstone, M. D., Chairman of the AMA Legislative Council, support the Medicredit measure

"As the nation's largest association of actively practicing physicians, the ones who will be called upon to provide the professional services which are contemplated under any program which may be authorized by Congress, we feel that our viewpoints are extraordinarily important," Doctor Roth told the committee.

"If we are to meet the principal needs not only of the aged and the poor but of the vast middle income group, it would seem we must endeavor to provide basic coverage for medical services and, if possible, add to this protection against ruinous catastrophic major medical expense (Senators Long and Abraham Ribicoff, (D-Conn.) are sponsors of a catastrophic-only type NHI proposal).

"We appreciate the economies of providing only catastrophic coverage, but feel that it will meet too few of the needs and will prove very difficult to administer. We appreciate the appeal of first dollar coverage but recognize the inordinate expense involved.

"The catastrophic coverage should be adjusted to ability to pay, since it is obvious that an amount which could be easy for the well-to-do family to pay could be disastrous for the much larger group of middle and low-income individuals. If the insurance is really to protect, it must be operative at the level of need.

"If I provide $10 worth of service for my patient and he pays me directly, I have earned $10 and he has spent $10. If, instead, money is to be collected from the patient as a tax to be transmitted to Washington, processed, transferred to another agency, processed, passed on to an intermediary, processed, and paid out as a benefit, and then reviewed for appropriateness, I will need to leave it to others to estimate how much more must be collected from the patient to yield the $10 necessary to cover the service rendered. Each complicating step in the process contributes to a shrinkage in service purchased by the medical dollar.

"We believe that the public will look with dismay on a financing mechanism which increases the Social Security tax by four per cent, as with the Kennedy-Mills proposal.

"We have enthusiasm for the financing mechanism in the Medicredit bill which uses tax credits to minimize the number of dollars making a round trip to Washington as tax to return as a shrunken benefit, and which places the obligation to contribute their share on those who have the ability to pay all or part of their premium cost. It uses an existing governmental collection agency, minimizes new demands for an increase in bureaucracy, and reduces administrative costs.

"Finally, there is the matter of administering the program. There is precious little evidence that any particular economy or efficiency results from government health programs, but a growing body that the opposite may be true.

"In the case of National Health Insurance, we feel assured that if any part of the funding derives from Social Security taxes there would be a compulsion for Social Security control of the program.

"We are confident that the administration of the program will best be accomplished by existing private entities in the field. Federal involvement, while inescapable when dealing with federal tax dollars, should be kept minimal.

"We again believe that our Medicredit program fulfills these objectives in respect to administration more aptly than does any other proposal to date."

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County Societies

MINGO

The Mingo County Medical Society met on May 8 with a "Ladies Night" Dinner at the Tug Valley Country Club in Williamson. Honored guests for the meeting were Dr. and Mrs. A. Thomas McCoy of Charleston. Doctor McCoy is President of the West Virginia State Medical Association.

Accompanying Dr. and Mrs. McCoy to Williamson was Charles R. Lewis of Charleston, Executive Director of the West Virginia Medical Institute, Inc.

Doctor McCoy spoke on the Professional Standards Review Organization from the standpoint of a physician while Mr. Lewis discussed PSRO as outlined by the U. S. Department of Health, Education and Welfare.—William H. Carter, M. D., Secretary.

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MONONGALIA

The Monongalia County Medical Society met on May 7 at the Old Mill Club in Morgantown.

The scientific program was given by Dr. David Z. Morgan, Professor of Medicine and Associate Dean of the West Virginia University School of Medicine. Doctor Morgan spoke on the coronary care program at the WVU Medical Center. Following his talk there was a lively period of discussion and questions.

A request for endorsement from the Region VI Planning and Development Council for a grant application to the U. S. Department of Health, Education and Welfare was read. The application was for funds to study the feasibility of and to plan for the development of a Regional Emergency Medical Services System. The grant application was endorsed by the Society.

The Society gave a vote of thanks to Dr. Robert J. Nottingham, who was to resign (effective July 1) as the Society's representative to the North Central Health Planning Association.

The Society also acknowledged the efforts of Dr. Eldon B. Tucker in behalf of the Aging and the T.R.I.P. programs.—H. Summers Harrison, M. D., Secretary.

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MERCER

The Mercer County Medical Society met on May 20 at the University Club in Bluefield.

The Director of Nursing and the Educational Director at Bluefield State College were guest speakers. They stated that the College is interested in promoting health career programs in addition to the degree program in nursing and asked support from the local medical community in the practical training aspect of these programs. Career programs which have been proposed include Dental Hygiene, Medical Assistants, Laboratory Assistants and X-ray Technicians.

The Society approved the Hypertension Screening Program of the Heart Association.—John J. Mahood, M. D., Secretary.

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FAYETTE

The Fayette County Medical Society met on May 8 at Oak Hill Hospital in Oak Hill. Dr. Herbert H. Pomerance, Director of Pediatrics at Charleston Area Medical Center, was the guest speaker. He gave a very informative discussion on office pediatrics.

It was announced that Dr. A. Thomas McCoy of Charleston, President of the West Virginia State Medical Association, would be the guest speaker at our June meeting.—Carl R. Adkins, M. D., Secretary.

° ° ° °

CABELL

Dr. Robert L. Bradley, Professor of Surgery at the University of Kentucky Hospital, was the guest speaker at the meeting of the Cabell County Medical Society on May 9 in Huntington. Doctor Bradley's interesting presentation was related to the treatment and cause of malignant disease.

Volunteers were requested and received to give physical examinations for an indigent children's summer camp sponsored by Marshall University.—Charles H. McKown, M. D., Secretary.

Book Reviews

HANDBOOK OF SURGERY—By John L. Wilson, M. D. Professor of Surgery, Stanford University School of Medicine, Palo Alto, California. Fifth Edition.

This book is designed for rapid reference and presents information in a very concise manner as an aid to the resolution of surgical problems. It has succeeded in this objective in a very creditable manner. The salient points can be quickly located and scanned.

There is presented detailed findings of tests to determine biochemical states, their variation from the normal, and the findings in cellular metabolism and physiology are also covered.

This book will be a valuable addition as a reference to anyone dealing with every-day surgical problems. I recommend it very highly.—Andrew J. Weaver, M. D.

CURRENT MEDICAL DIAGNOSIS & TREATMENT —By Several authors. Lange Medical Publications, Drawer "L", Los Altos, California. Price: $12.00

This is an annual edition of a well-received text, helpful for relaxed reading, reference and instruction.

There are multiple authors, all masters in the section of medicine on which they are writing. It is well printed

(Continued on page xv)

and quite readable. There are substantial additions and changes over preceding volumes.

The price is right — $12.00, which is a bargain in this day of inflated medical book costs.

HANDBOOK OF POISONING—By Robert H. Dreisback. Lange Medical Publication, Los Altos, California. 8th Edition. 517 Pages. Price: $6.50

There are 517 packed pages of information in this pocketbook. The book covers all manner of poisons — agricultural to medicinal. Five-hundred recent references have been analyzed in this eighth edition.

The book is valued throughout the world and translated into many foreign languages. There is an interesting section on the legal and medical responsibility in poisoning, and there is a 68-page index of all substances and inhalants that may give rise to toxic complaints.

It is a useful little book to have around.

State Physicians Elected to ACP Offices At Annual Session

Edmund B. Flink, M.D., of Morgantown was one of eight physicians elected to the American College of Physicians Board of Regents at the ACP Annual Session this past spring in New York City.

Jack H. Baur, M.D., of Huntington was elected to serve as an ACP Governor while John E. Jones, M.D., of Morgantown was voted into office as a Governor-Elect.

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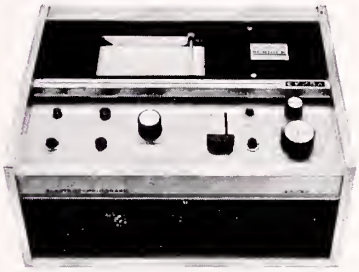

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Annual Audit, 1973

The annual audit of receipts and disbursements of the West Virginia State Medical Association for the calendar year 1973 has been completed by the firm of Ernst & Ernst, Certified Public Accountants of Charleston. The complete audit, with letter of transmittal, follows:

ERNST & ERNST
Charleston National Plaza
P. O. Box 2906
Charleston, West Virginia 25330

To The Council
West Virginia State Medical Association
Charleston, West Virginia

We have examined the statements of assets, liabilities, and fund balances arising from cash transactions of the several funds of the West Virginia State Medical Association as of December 31, 1973, and the related statements of revenues collected and expenses paid and changes in fund balances for the year then ended. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the aforementioned financial statements present fairly the assets, liabilities, and fund balances arising from cash transactions of the several funds of the West Virginia State Medical Association at December 31, 1973, and the revenues collected and expenses paid and changes in fund balances during the year then ended on a basis consistent with that of the preceding year.

ERNST & ERNST

Charleston, West Virginia
March 15, 1974

STATEMENTS OF ASSETS, LIABILITIES, AND FUND BALANCES ARISING FROM CASH TRANSACTIONS

WEST VIRGINIA STATE MEDICAL ASSOCIATION

December 31, 1973

ASSETS

GENERAL FUND	
Cash	$ 640
Certificates of deposits	62,500
Other assets	36
	$ 63,176
MEDICAL SCHOLARSHIP FUND	
Cash	$ 30,200
Certificates and time deposits	7,000
Due from general fund	7,875
	$ 45,075

LIABILITIES AND FUND BALANCES

GENERAL FUND	
Notes payable to bank	$ 15,000
Due to medical scholarship fund	7,875
Fund balance	40,301
	$ 63,176
MEDICAL SCHOLARSHIP FUND	
Fund balance	$ 45,075

See note to financial statements.

STATEMENT OF REVENUES COLLECTED AND EXPENSES PAID — GENERAL FUND

WEST VIRGINIA STATE MEDICAL ASSOCIATION

Year ended December 31, 1973

Revenues collected:	
Dues	$257,599
Advertising	21,620
Consulting fees	6,000
Exhibit space	4,625
Other revenues	6,726
	296,570
Expenses paid:	
Salaries and wages	63,674
Employee benefits	4,074
Taxes — payroll and other	2,983
Dues remitted to AMA	132,015
Office rent	6,942
Office supplies and expense	9,366
Telephone	4,411
Travel	16,987
Postage	3,225
Publishing and printing	29,612
Convention speakers and supplies	16,612
Other expenses	9,233
	299,134
EXPENSES PAID IN EXCESS OF REVENUES COLLECTED	$ (2,564)

See note to financial statements.

STATEMENTS OF CHANGES IN FUND BALANCES ARISING FROM CASH TRANSACTIONS

WEST VIRGINIA STATE MEDICAL ASSOCIATION

Year ended December 31, 1973

	General Fund	Medical Scholarship Fund
Balance, December 31, 1972	$42,865	$43,238
Excess of expenses paid over revenues collected	(2,564)	—
Dues	—	8,016
Repayment of scholarship	—	800
Interest collected	—	1,486
Other	—	35
Payment of scholarship installments	—	(8,500)
Balance, December 31, 1973	$40,301	$45,075

See note to financial statements.

NOTE TO FINANCIAL STATEMENTS (CASH BASIS)

WEST VIRGINIA STATE MEDICAL ASSOCIATION

Year ended December 31, 1973

NOTE A — BASIS OF PRESENTATION OF FINANCIAL STATEMENTS

The financial statements are presented using the cash basis of accounting. Office equipment and other capital expenditures are charged to expense at the time of purchase. Interest on certificates of deposits is paid to the Association at dates of maturity and is included in income upon receipt. Certificates of deposits outstanding at December 31, 1973, were purchased in 1969 and 1972, and mature in 1974. Therefore, interest on these certificates of deposits will be collected and recorded in 1974.

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M. E. Nugent, M. D.
R. V. Pangilinan, M. D.

Eor, Nose & Throat:
W. A. Tiu, M. D.

Orthopedic Surgery:
E. L. Barrett, M. D.

Thorocic Surgery:
Daniel W. Dickinson, M. D.

Obstetrics ond Gynecology:
Robert W. Leibold, M. D.
Robert T. Brandfass, M. D.
A. Athari, M. D.

Urology:
D. C. Trapp, M. D.

Dermatology:
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Sheldon Widlan, M. D.

Internal Medicine:
Charles H. Hiles, M. D.
Albert M. Valentine, M. D.
C. A. Vasquez, M. D.
T. E. Chvasta, M. D.

Psychiatry and Neurology:
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Stephen D. Ward, M. D.
Michael McNeer, M. D.
David Hill, M. D.
David H. Smith, M. D.
Robert L. Mendelson, Ed D.

Roentgenology:
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J. N. Aceto, M. D.

Speech Pothologist ond Audiologist:
James P. Frum, M. S.

Clinicol Loboratories:
Donna Burlenski
Donna Bryan

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Electrocardiography:
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Brenda Muklewicz, R. N.
Electroencephalography:
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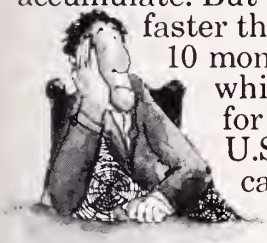

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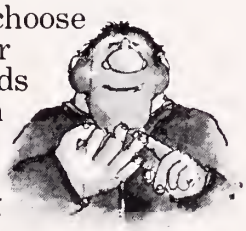

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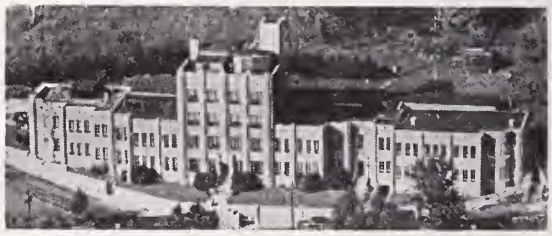

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T. H. Chang, M. D.
J. W. Woodford, M. D.

Gynecology and Obstetrics:
Raymond W. Cronlund, M. D.

Internal Medicine:
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B. G. Thimmappa, M. D.
Karl J. Myers, Jr. M. D.

Pediatrics:
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Eugene Warvariv, M. D.
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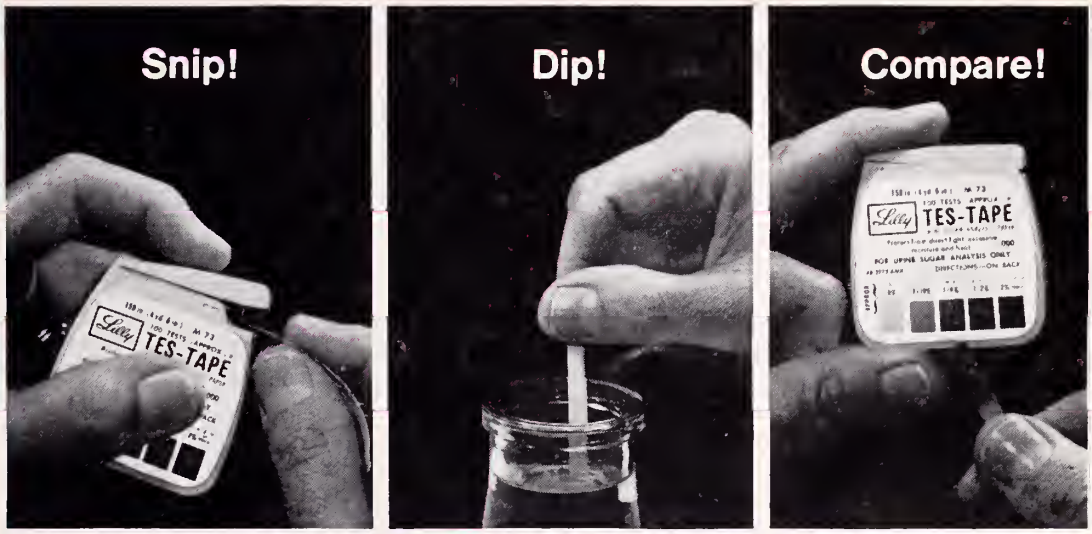

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Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase and/ or severity of grand mal require increased dosage of convulsant medication; abrup may be associated with tempo crease in frequency and/ or se seizures. Advise against simul gestion of alcohol and other C sants. Withdrawal symptoms those with barbiturates and al occurred following abrupt dis (convulsions, tremor, abdomi cle cramps, vomiting and swe addiction-prone indlviduals ur

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two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

For further information on this subject, the following references are provided:

1. Henry BW, *et al: Dis Nerv Syst 30*:675-679, Oct 1969.
2. Hollister LE, *et al: Arch Gen Psychiatry 24*:273-278, Mar 1971.
3. Claghorn J: *Psychosomatics 11*:438-441, Sept-Oct 1970.

Valium® (diazepam)

2-mg, 5-mg, 10-mg tablets

in psychoneurotic anxiety states with associated depressive symptoms

e because of their predisposi-
ituation and dependence. In
, lactation or women of child-
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barbiturates, MAO inhibitors
antidepressants may potentiate
Usual precautions indicated in
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n, or with suicidal tendencies.

Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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AUGUST
1974

Vol. 70 No. 8

The WEST VIRGINIA Medical Journal

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The Role of the Detail Man

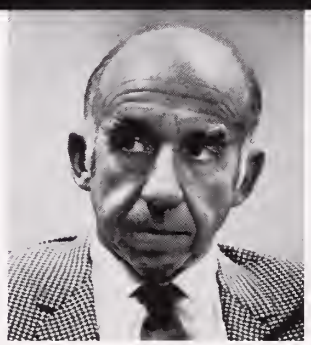
Opinion & Dialogue

Dr. Willard Gobbell
Family Physician
Encino, California

"I may be prejudiced, but I very much in favor of the detail r I meet. Most of them are knowled able about the drugs they promo and can be a great help in acqua ing me with new medication."

Family Physician's Perception

I think that most general practitioners in this area feel as I do about the detail man. Over the years I have gotten to know most the men who visit me regularly a they in turn have become aware my particular interests and the n ture of my practice. They, therefore, limit their discussion as mu as possible to the areas of intere to me. Since I usually see the sar representative again in future visits, it is in his best interest to supply me with the most honest, factual, as well as up-to-date information about his products.



Dr. Jeremiah Stamler
Chairman
Department of Community Health and Preventive Medicine, and Dingman Professor of Cardiology
Northwestern University Medical School

"In the total picture of deali with health problems in this cour there is a potential for detail mer to play a meaningful role."

The Positive Influence

My contact with representa tives and salesmen of the pharma ceutical industry is the type of co tact that people in a medical centr, research people, and academic people have and that's in all likeli on a somewhat different level fro that of the practicing physician.

Let me touch on how I perso ally perceive the role of the sales representative. These men reach large numbers of health professionals. Thus they could be—and at times actually are—disseminators of useful information. They could consistently serve a real ed cational function in their ability to discuss their products.

At present they do distribute printed material, brochures and pamphlets—some of it scientifically sound and therefore truly use ful—as well as some excellent filr produced by the pharmaceutical industry. When they function in th

e a Source of Information?

Yes, with certain reservations. average sales representative a great fund of information ut the drug products he is re- nsible for. He is usually able to wer most questions fully and lligently. He can also supply rints of articles that contain a at deal of information. Here, , I exercise some caution. I usu- accept most of the statements l opinions that I find in the ers and studies which come m the larger teaching facilities. oes without saying that a physi- n should also rely on other rces for his information on armacology.

ining of Sales Representatives

Ideally, a candidate for the sition as a sales representative a pharmaceutical company uld be a graduate pharmacist o has a questioning mind. I don't nk this is possible in every case, d so it becomes the responsibility of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

---

pacity they are indeed useful; rticularly in the fact that they sseminate broadly based educa- nal material and serve not just "pushers" of their drugs.

e Other Side of the Coin

Obviously, the pharmaceuti- l companies are not producing all is material as a labor of love— ey are in the business of selling oducts for profit. In this regard e ambitious and improperly moti- ted sales representative can ert a negative influence on the acticing physician, both by pre- nting a one-sided picture of his oduct, and by encouraging the actitioner to depend too heavily drugs for his total therapy. In ese ways, the salesman has often istorted objective reality and ndermined his potential role as an ducator.

he Industry Responsibility

Since the detail man must be n information resource as well as representative of his particular harmaceutical company, he hould be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—*i.e.,* the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that information must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

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With the means at hand to drastically reduce the number of deaths each year from uterine cancer, we have embarked on a nationwide, life-saving program. Its goal is a Pap test by 1976 for every woman 20 years or older to whom the test is applicable, and for younger women at risk. An ambitious program, doctor, and one which can only be realized with your help.

We are faced with these facts: only 53% of women over 20 have ever had a Pap test; only 20% get a Pap test periodically; each year about 43,000 new cases are diagnosed; this year 12,000 women in this country will die of uterine cancer. And about 75% of these deaths will result from cervical cancer—as you know, almost 100% curable when diagnosed early and treated promptly.

We hope to reach women in the target group not only with the message about the *vital* Pap test, but also with the urgency of including it in the *regular* health checkup. The mortality rate from uterine cancer could thus be dramatically curtailed.

Clearly action is called for. Coordinated action—involving the doctor, the patient, the American Cancer Society—a partnership for life.

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Vol. 70, No. 8 August, 1974

Slow Viruses And Degenerative Brain Diseases*

Samuel M. Chou, M. D., Ph. D.

Over the past decade, "slow virus infections" has become a household word of neuroscientists and virologists. No less than 30 human diseases have been implicated with possible slow virus infection etiologies, including neoplasms, autoimmune diseases, geriatric diseases and congenital diseases. Yet in only five has this been convincingly proven to be the case, and all of them are central nervous system (CNS) diseases. There must be some reason or reasons yet unknown to us for the CNS being the site of preference for slow virus infections. At the present time, it seems reasonable to speculate that many of the progressive CNS diseases e.g. multiple sclerosis, amyotrophic lateral sclerosis, Parkinson's disease etc., (Table 1), may be caused by slow virus infections. Infectious etiology of the first five diseases on the list has been firmly established during the past decade.

This remarkable fast pace of the progress in the understanding of these protean brain diseases might not have been possible without the concept which was derived from the elegant studies on spontaneous animal diseases. The studies of "rida," "maedi," and "visna," entirely exotic diseases in Icelandic sheep, led Doctor Sigurdsson to postulate a new concept of "slow virus infection" in 1954. He considered the slow virus infection to be characterized by (1) an initial long period of incubation of many months or years without overt signs of clinical disease, (2) a progressive protracted course after clinical signs have appeared ending in serious disease or death, and (3) limitations of the infections to a singly host species and localization of lesions within a single organ or tissue system. The third criterion has had to be revised in the light of recent progress of our knowledge on slow virus infections as will be discussed below.

The Author

- **Samuel M. Chou, M. D., Ph. D., Professor of Neuropathology, West Virginia University School of Medicine, Morgantown.**

It was pointed out that a strange paralytic fatal disease of Icelandic sheep, "visna," causing inflammatory demyelination and destruction of the white matter in the brain, mimics closely the acute phase of human multiple sclerosis. The disease can be transmitted to normal sheep, but it appears one or two years after the inoculation, in spite of persistent asymptomatic meningitis evidenced by spinal fluid pleocytosis. Another unusual feature noted is the absence of

TABLE 1

Degenerative Brain Diseases Implicated With Slow Virus Infection

A. Kuru.
B. Creutzfeldt-Jacob Disease.
C. Subacute Sclerosing Panencephalitis (SSPE).
D. Progressive Multifocal Leukoencephalopathy (PML).
E. Subacute Focal Adenovirus Encephalitis (SFAE).
F. Multiple Sclerosis (MS)
G. Amyotrophic Lateral Sclerosis (ALS).
H. ALS-Parkinsonism - Dementia of Guam.
I. Parkinson's Disease.
J. Alzheimer's Disease.
K. Pick's Disease.
L. Schilder's Disease.
M. Leucodystrophies.

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detectable circulating neutralizing antibodies in the infected sheep.

A peculiar sheep disease, "rida," extensively studied by Sigurdsson is now considered identical to scrapie, the slow virus disease of greatest antiquity. This chronic progressive fatal disease of sheep and goats, was known in England for over 200 years and was long considered as a hereditary disease by sheep farmers. Scrapie was first transmitted to healthy sheep in 1936, by inoculation of brain suspension from scrapie sheep with a long incubation period of one to five years. Since then, the disease has been induced in seven other animal species.

Remarkable genetic predispositions to the disease have been shown among different breeds of sheep. In addition to rubbing and scratching the skin, from which the name was derived, the disease is characterized by the insidious onset of tremor, gait and truncal ataxia, impairment of vision and debility. The pathological changes are limited to the CNS, even though infective agents can be recovered also from the spleen, thymus and salivary glands. Histopathologic changes, which are confined in the gray matter, consist of vacuolization and degeneration of neurons, astrocytic hypertrophy and status spongiosus (Figure 1a). It was these characteristic pathologic features that unveiled the mystery of a puzzling human disease, kuru, and linked the latter to the slow virus infections. In 1959, Hadlow pointed out the close similarities of the neuropathologic pictures of scrapie and kuru.

In 1966, Carlton Gajdusek and Clarence Gibbs at the National Institutes of Health, transmitted kuru to chimpanzees 18-30 months after intracerebral inoculation of brain suspension prepared from the brains of human kuru victims. Later, they succeeded in serial transmission of kuru from chimpanzee to chimpanzee and also to several other species of primates. Pathological findings of experimental kuru in chimpanzees are very similar, if not identical, to those of human kuru. Since kuru was thought of as an isolated, exotic hereditary disease occurring only in the highland interior of New Guinea, the impact of these exciting experimental results seemed not overwhelming at the moment.

However, when another unique brain disease causing presenile dementia, Creutzfeldt-Jakob (C-J) disease, was successfully transmitted to chimpanzees, after an incubation period of 13 months, in 1968, the contention of other degenerative brain diseases being caused by slow virus infection was greatly enhanced. Many common curious facets observed in both kuru and C-J diseases as well as scrapie and transmissable mink encephalopathy (TME), prompted Gajdusek and Gibbs to separate these four diseases and designated them as "subacute spongiform encephalopathies." Separation of this group from the rest of slow virus infection was well supported at the Slow Virus Workshop held in Budapest in 1972. Opinion has been expressed that kuru and C-J disease may be the same disease, but have evolved under different environmental and genetic circumstances.

The link between these two diseases appeared strengthened when "kuru-plaques", a pathologic change (Figure 1b), which was thought to be unique to kuru brains, was found in a case of C-J disease from West Virginia. The patient, a 64-year-old retired miner, developed progressive truncal and gait ataxia, personality change and dementia and died 10 months after the onset. In

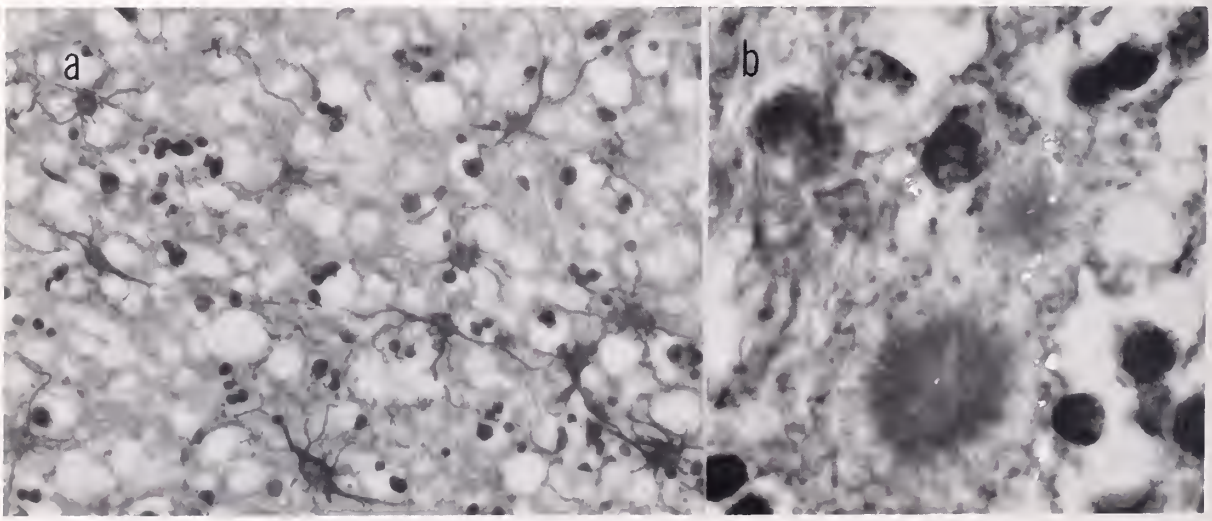

Figure 1a. Characteristic status spongiosus, astrocytic proliferation and hypertrophy in the brain of a patient with Creutzfeldt-Jakob disease (x 500 Holzer stain). Figure 1b. "Kuru plaques," fibrillary bodies with radially arranged fibrilles, in the cerebellum of a patient with Creutzfeldt-Jakob disease (x 2000 Bodian stain).

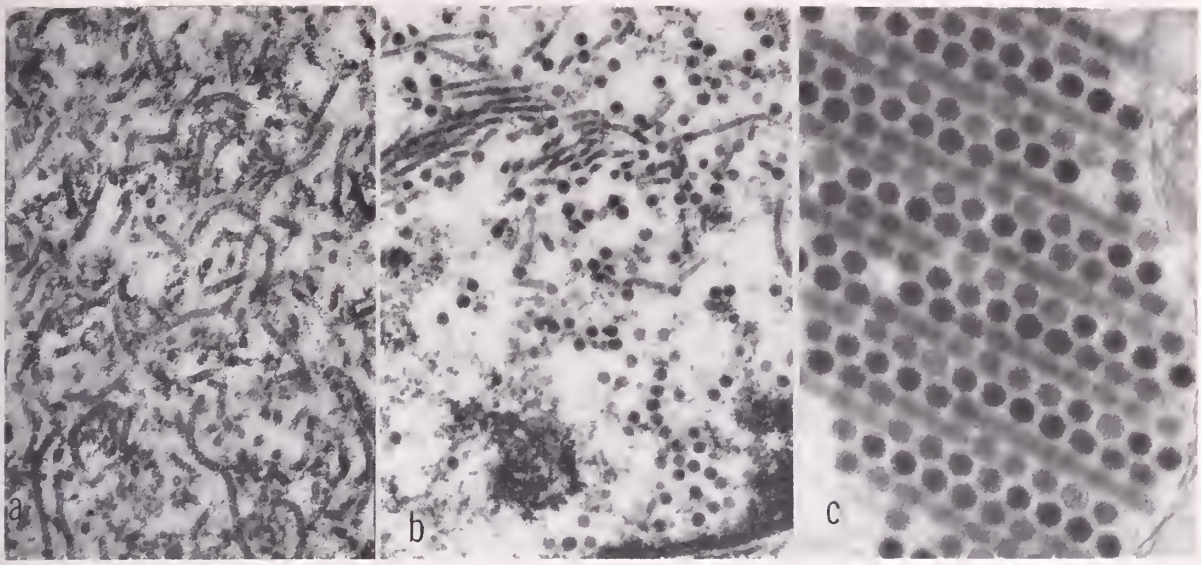

Figure 2a. Intranuclear filaments, 20 to 30 nm. in diameter, with tubular profile in cross sections, characteristic of nucleocuspids from measles virus, in a patient with SSPE (x 52,000). Figure 2b. Intranuclear viral particles (40 nm. in diameter) and filamentous particles (20 nm. in transverse diameter) in a nucleus of oligodendroglia from a patient with PML (x 52,000). Figure 2c. Intranuclear viral particles, 75 nm. in diameter, forming crystal array in a neuronal neucleus from a patient with SFAE (x 52,000).

addition to typical histopathological changes of status spongiosus, neuronal vacuolization and degenerative and astrocytic hypertrophy, numerous "kuru-plaques" in the cerebellum have been demonstrated. On electron microscopy, the kuru-plaque consists of radically arranged microtubular filaments measuring 120-150A° in diameter. By virtue of a careful history taken by my colleague, Dr. James D. Martin, the information was obtained from the patient's family that the patient had eaten "hog brains" seasonally as a young man.

At the report of the fascinating history of habitual ingestion of hog brains, together with unmistakable kuru-plaques in the brain of our patient, the investigators at the National Institutes of Health started to investigate the incidence of consumption of hog brains in all the patients with C-J disease and found that 50 per cent had eaten hog brains. It is well established that the transmission of kuru is by the cannibalistic ingestion of human brain and the incidence of kuru has markedly diminished among the Fore tribe since 1963 when cannibalism was eliminated.

In 1971, Doctor Morley of Australia reported that incidence of eating sheep's brains more than twice a year was significantly higher in 20 multiple sclerosis patients (11 out of 20) compared with 40 control patients (12 out of 40). Although the finding was later refuted, it is not entirely improbable that there may exist dormant transmissible agents in many animal brains, including ours, which may eventually become the causative factor of degenerative brain diseases. Transmissions by ingestion of the brain, even cooked, is feasible since we are dealing with an infectious agent which is resistant to heat, protein coagulants and perhaps the many spices and alcoholic beverages which would be taken together with this popular delicacy.

The infectious agents of the subacute spongiform encephalopathies were consistently found in association with membrane preparations. Yet, viral particles have never been convincingly demonstrated in the brain or cultured tissue with the electron microscope. On electron microscopy, however, the membranes frequently showed abnormal thickening or swelling with signs of proliferation. The infectious agents of subacute spongiform encephalopathies possess unusual properties unknown to the conventional viruses. They are resistant to heat, formalin and ultraviolet light. These extraordinary properties, which are clearly incompatible with those of conventional viruses, have led researchers to propose many tantalizing hypotheses that the agent may, in fact, be: (1) "protovirus," which is incorporated into the genome of the host cells, (2) "icron," which is composed largely of serum protein components, (3) "membrane," itself, which integrates and envelopes a small, simple nucleic-acid fragments, (4) "linker," the linkage substance which binds tightly the DNA-containing macromolecules to cellular membranes, thereby becoming a complete infectious complex, and (5) "viroids," infectious low-

molecular-weight RNA, capable of causing plant diseases.

Irrespective of all these theoretical considerations, we are clearly dealing with a new group of infectious agents which somewhat resemble virus in their infectivity but not in their physiochemical properties. To date, there is no evidence that antibody is made to these subacute spongiform encephalopathies. This might serve as another important criterion to separate them from the rest of the slow virus infections.

Let us now turn our attention to a group of degenerative brain diseases caused by slow infection of bona-fide viruses which may be "suppressed" or "masked." Subacute sclerosing panencephalitis (SSPE), progressive multifocal leucoencephalopathy (PML) and subacute focal adenovirus encephalitis (SFAE), are relatively new members of brain diseases due to slow virus infections with immunopathic overtones.

SSPE was first described by Dawson in 1933 in two children from Tennessee with subacute encephalitis. Dawson suspected a viral etiology, but was unable to confirm it. Since then, approximately 300 cases have been collected in the literature under various terms, e.g. Dawson's encephalitis, van Bogaert's disease, subacute sclerosing leucoencephalitis, nodular panencephalitis, subacute inclusion body encephalitis, encephalitis of Pette-Doring, etc. On electronmicroscopy, Bouteille et al. demonstrated myxovirus-like particles in affected brain material in 1965 (Figure 2a). Measles virus as the etiologic agent was suggested and supported by others. High titers of anti-measles antibodies were found in both the serum and CSF. In 1969, measles virus was isolated from a brain biopsy specimen by Baubis and Payne and confirmed by others.

PML was first described in 1958 by Astrom et al. as a unique demyelinative disease associated with malignant diseases of the reticuloendothelial system, such as leukemia and lymphoma. Since then, about 100 cases have been documented. In 1964, ZuRhein and Chou demonstrated with the electron microscope, papovavirus-like particles in the inclusion bodies of oligodendroglia and similar viral particles have been described in 30 additional PML cases (Figure 2b). In 1971, a new papovavirus was cultivated in cultured human fetal glial cells and was called the J-C virus. This virus appears to be potentially oncogenic; when the newborn hamsters were intracerebrally inoculated with J-C virus, 83 per cent of the animals developed brain tumors within six months.

SFAE was first described by us in 1971, in a patient from West Virginia with a lymphoma for five years during which time the patient had received extensive immunosuppressive treatment. Crystalline aggregates of adenovirus particles were seen in the inclusions of neuronal nuclei (Figure 2c). During the following year, type-32, a new member of adenovirus was isolated from human embryonic kidney cells and HeLa cells.

There appears to be a stereotyped pattern in elucidating the etiologic agent in each disease. In each instance, after the clinicopathologic entity was established and specific intranuclear inclusions described, electron microscopy led the way and gave virologists the clue as to what type of virus to cultivate and investigate. The complete definition of the entire entity requires the careful teamwork by clinicians, pathologists, electronmicroscopists and virologists.

The clinicopathological features of these three diseases are reviewed below. *SSPE,* is a progressive disease of childhood usually presenting with inappropriate behavior, intellectual deterioration, and periodic myoclonic jerks. The clinical course usually terminates after several months, although longer survivals, up to nine years and an exceptional case of recovery, have been reported. High titers of antimeasles antibodies can be demonstrated in both serum and CSF during the course of the disease. Histopathologically, aside from nonspecific features of viral encephalitis, there are foci of gliosis and demyelination. The most crucial finding is that of the eosinophilic intranuclear inclusions of Cowdry type A, and intracytoplasmic inclusions in both neurons and neuroglia.

On electron microscopy, the inclusion is composed of interwoven filaments, 20 to 30 nm. in diameter, with definite tubular profile in cross section, and with transverse periodicity of 10 nm. in longitudinal section. The tubular structures are similar to the nucleocapsids of measles virus. Even with these impressive findings, it took three years to isolate measles virus from the brains of patients with SSPE. The difficulty in isolation of the virus, was thought to be due to the measles virus being "incomplete" or "suppressed".

According to the recent epidemiologic study, more than 50 per cent of SSPE patients had had measles before the age of two years and that the average duration from the measles infection to the onset of SSPE was estimated to be six years. This implies that the measles virus has never been eliminated but suppressed in the patients' brain cells during those years. The failure in elimination was considered to be due to the defect in the cell-mediated (or thymus-dependent) immunity. Since SSPE patients have

higher titers of antimeasles antibodies in both serum and CSF, than average individuals, the humoral (or gut-dependent) immunity should be normal.

The clinical course of PML, a progressive brain disease of late adulthood, usually associated with malignancies of reticuloendothelial system terminates fatally between two to six months. We have recently reported the second case of PML from which the J-C virus, a new human papovavirus, was isolated.

This patient, a 50-year-old male, had survived for 12 years after he was diagnosed as having Hodgkin's disease. He had been extensively treated with corticosteroids, cytotoxic agents and radiation. Two months before death, he developed progressive weakness and sensory loss of his left arm and visual defects. Terminally, the patient had left hemiparesis, left homonymous hemianopsia, and developed grand mal seizures and loss of consciousness three days before death. Multifocal and massive demyelinative foci were found in the right parieto-occipital white matter at the time of autopsy and brain specimens from these lesions were taken and frozen immediately for virologic studies. A few disseminated foci were seen in the left hemisphere and also in the gray matter.

On light microscopy, three characteristic features were: (1) multifocal confluent foci of demyelination, (2) bizarre giant astrocytes with a malignant appearance, and (3) intensely basophilic intranuclear inclusions of oligodendroglia. The intranuclear inclusion, as seen with the electronmicroscope, were composed of papovavirus particles measuring 40 nm. in diameter mixed with filamentous forms of 22 nm. in average diameter. Less frequently, the inclusion was composed, in part, of crystalline arrays of viral particles. The brain homogenate from the frozen brain specimens, was inoculated to the cultured human fetal glial cells, which normally demonstrate 2 different cell populations, i.e. the densely-stained and small spongioblasts, and the lightly stained and large astrocytes.

After three passages, characteristic cytopathic effect, similar to that observed on the first J-C virus isolation, were noted. The cytopathic effect is characterized by compact eosinophilic intranuclear inclusions in spongioblasts and gigantic bizarre astrocytes, with either vesicular multilobulated or dense basophilic nuclei, resembling those seen in the brain sections. Electron microscopy on the infected human fetal glial cells, revealed the viral particles in cubic, filamentous and crystal forms, similar to those observed in the patient's brain. Negatively stained viral particles, prepared from both the brain specimens and from the infected PHFG cells were compared. They both measured 42 nm. in diameter and had the same number of capsomere, 72, counted according to Klug and Finch method. Indirect immunofluorescence was positive in cell nuclei with J-C antiserum, but negative with SV_{40}-antiserum. Large nuclei of gigantic astrocytes often showed positive fluorescent antibody staining. Hemagglutination-inhibition tests, with rabbit anti-J-C-serum and the calf anti-serum against SV_{40} virus, indicated that the isolate was identical to J-C virus.

Recent serological assay for serum antibodies against J-C virus indicates that about 70 per cent of 277 "normal" adults tested had antibodies to J-C virus, and most had apparently had J-C virus infections occurring during childhood. The results would imply that the latent infection with J-C virus may persist in the majority of adults and PML may ensue when the latent infection is activated as a result of acquired immunologic deficits such as in reticuloendothelial malignancies or therapeutic immunosuppression.

A similar patholgenic mechanism may be applicable to SFAE, a new subacute encephalitis only recently described at West Virginia University. The patient, a 42-year-old white male, was diagnosed as having lymphoma five years before death and received various chemotherapies, steroids and radiation therapies. Disturbance of consciousness, and convulsions with head and eye deviation to the right developed approximately four weeks prior to death. Marked hypogammaglobulinemia was present and CSF study showed a marked increase in protein.

At autopsy, a well localized area of cystic malacia with brown discoloration was noted over the left occipital lobe extending into the fusiform gyrus of the left temporal lobe. The surfaces of the involved area were covered with finely granular white patches of calcification. The cortical ribbons of the involved areas were markedly thinned and show yellowish discoloration accompanied with numerous petechial hemorrhages. No macroscopic abnormalities were noted in the rest of the brain. Microscopically, finely granular calcium deposits were present in the subpial and molecular layers of the affected cortex. In addition to the non-specific changes of viral encephalitis, there was dense infiltration of astroglia and microglia.

The most striking findings were numerous densely basophilic gigantic nuclear inclusions of the cortical cells. The basophilic amorphous

material appeared to have completely replaced the nuclear chromatin. No halo or nuclear membrane could be seen. The cytoplasm was eosinophilic and rounded; no Nissl substance or cellular processes was noticeable. Indirect immunofluorescence, with polyvalent antiadenovirus serum demonstrated brilliantly stained nuclear inclusions.

On electron microscopy, the nuclear inclusions were composed of markedly electron dense, finely granular material in which crystalline arrays and individual viral particles were embedded. The outline of the nuclear inclusions were not easily defined since the nuclear membranes were partially disrupted or often totally absent. Most of the nuclei involved were identified as neuronal and less frequently as the microglial or oligodendroglial.

The viral crystalline arrays were composed of alternately arranged dense and light particles which tended to show hexagonal profiles. The virions measured 72 nm. in average diameter with central cores of varied electron density measuring 48 nm. in diameter. Negative staining, with PTA of the virions obtained from the brain homogenate demonstrated the number of capsomeres to be 252, indicative of adenovirus. An adenovirus, closely related to type-32 with low-level cross neutralization with type-27 and type-9, was isolated from the frozen brain tissue in human embryonic kidney (HEK) cells in which basophilic similar nuclear inclusions were observed. Electron-microscopy of these HEK cells reveal identical viral crystals and particles within the same components of the nuclear inclusions seen in the brain.

Since adenoviruses are known to be normal inhabitants of human tonsils, adenoids or respiratory tracts, SFAE may conceivably result when a latent adenovirus becomes activated by severe immunosuppression or the hypoimmune status of the patient.

In reviewing the immunological state in each of these three slow virus infections, it becomes quite clear that a failure in cellmediated immunity plays an important role in the pathogenesis. The role of humoral antibody and interferon in slow virus infection is uncertain. Both neutralizing antibody and circulating interferon would reduce the initial viremia and protect cells in target organ from subsequent viremia, thereby playing an important role in defending against acute viral infections. Once the virus has entered inside the neurons, the infections may persist in the presence of neutralizing antibody. Conversely, as in the "persistent tolerant infections," e.g. lymphocytic choriomeningitis (LCM) virus infections in mice, no neutralizing antibody can be detected. Thus, immunological approach becomes essential in the understanding of slow virus diseases.

In this regard, Hotchin is justified to revise the general properties of slow viruses as follows: (1) they actively multiply in the host for long

TABLE 2

Measles Virus Infection of Brain (Hypothetical)

	"Primary"	"Secondary"	"Tertiary"
Disease Entity	Post-Measles Encephalitis	Subacute Sclerosing Panencephalitis (SSPE)	Multiple Sclerosis (MS)
Clinical Cause	Acute	Subacute	Chronic with Remissions
Incubation periods	2 wks-1 month	6 years	20 years
Age Incidence	1st Decade	1st to 2nd Decade	3rd to 4th Decade
Pathology	Perivascular demyelination & inflammation Inclusion (±)	Perivascular inflammation. Astrocytic hypertrophy. Cowdry A(±)	Demyelination & gliosis in "plaques". Inflammation (±) Inclusion (—)

periods of time without apparent disease, (2) they are not recognized as "foreign" by the host, (3) an immune reaction to such tolerant agents either is very late or does not occur at all, and (4) the final disease produced may be an autoimmune response caused by termination of the tolerance, although the final disease may be a gradual process of "erosion" of the affected cells by virus.

Hence, different types of slow virus infections, relative to the host's immunological state, become possible. A group of so-called autoimmune diseases may fit comfortably to one of the categories of slow virus infections. Multiple sclerosis (MS) which has been considered as an autoimmune disease, may in turn be a slow virus disease. Several epidemiologic studies on MS have hinted the possibility of a viral etiology and suggested an incubation period of about 15 to 20 years between the time of exposure to the virus and the onset of the symptoms. Serologic studies indicated, although equivocally, the MS patients have more measles antibody in their serum than controls. In 1965, Palsson et al. reported that several of the sheep which were inoculated with the brain homogenate from the MS patients, developed a disease similar to scrapie. The finding was not confirmed by other investigators. Myxovirus-like particles have been described with electron-microscopy in the brains of MS patients by three groups of researchers and measles virus is a member of myxovirus group.

It may not be too presumptuous to suggest that, as in syphilis, post-measles encephalitis, SSPE and MS might be designated as the primary, secondary and tertiary measles virus infection respectively (Table 2). It has been known that the primary syphilis occurs 10 days to two months after infection, the secondary syphilis up to five months later, and the tertiary syphilis up to 30 years later. We know virtually nothing about the mechanism responsible for development of the secondary or tertiary syphilis although hyperimmunity or autoimmune mechanism has been entertained. Primary and secondary syphilis may infrequently go unrecognized only to be followed by the tertiary syphilis. The analogy can be drawn for MS; the primary measles infection may be forgotten or unrecognized, as is also the case in SSPE.

The early studies on syphilis and bacterial infections, initially satisfying only the curiosity of scientists, assumed great importance when therapeutic measures became available to prevent, treat and cure these diseases. Similarly, the studies and concepts dealing with degenerative brain diseases, discussed in this paper, are, for the present, only of academic interest. However, antiviral agents of limited effectiveness are already beginning to emerge. It is hoped that broader spectrum antiviral agents and/or agents to restore defective immunity will be discovered in the not too distant future. The present discussion will then assume a much greater practical significance. In the interim, we will need to continue our quest to further unravel the enigma of this challenging and puzzling group of disease which have the most tragic consequences for the patient and his family.

A Better Method Than Vasectomy?

DUTCH scientists have developed a surgical procedure which may point the way to bypassing the potential difficulties of vasectomy on a long-term basis, according to the National Society for Medical Research. Doctor M. V. Van Andel of Erasmus University in Rotterdam told scientists attending a fertility control conference in Genoa, Italy that he and his colleagues attach the vas deferens to the bladder so that the sperm empty into that organ. Doctor Van Andel says this procedure is reversible in rats and it avoids the formation of sperm antibodies. These two advantages are not enjoyed with the present method of blocking the spermatozoa in the vasa deferentia.

The procedure, referred to as vasocystostomy, also seems to do away with such effects as cyst formation and vasodilatation, an increase in the size of the tubes. More animal research is needed before the Dutch group's findings can be applied to humans, but the investigators feel this line of study is very promising.

Special Article

Let's Make High School Football Safer

K. Douglas Bowers, Jr., M. D.

MUCH has been done during the past two decades to reduce both the incidence and the severity of football trauma. Rule changes aimed at enhancing player safety, mandatory wearing of mouth-pieces, and the development of more sophisticated equipment are but a few examples. Still we continue to see a rather large number of injuries each year among high school football players. When the individual injuries are investigated many are found to be caused, at least in part, by factors which should be for the most part controllable. It follows, therefore, that if these factors are maximally controlled the incidence and severity of high school football injuries can be further reduced.

The Author

- **K. Douglas Bowers, Jr., M. D. Associate Professor, Orthopedic Surgery, West Virginia University School of Medicine, and Physician to the Athletic Department, WVU, Morgantown.**

Factors Contributing to Injury Which are Controllable

Inadequate Equipment. Most schools today have adequate football gear; however, we still see injuries which seem to have resulted from old worn out equipment or from previously damaged equipment which was never repaired but continues to be used. There is absolutely no justification for allowing a player to participate in competitive high school athletics without adequate protective gear. If such equipment is lacking, participation should not be allowed.

Improper Fitting Equipment. Poorly fitting helmets and shoulder pads are the big offenders, predisposing players to facial, cervical spine, shoulder girdle, and upper extremity trauma. The intended purpose of protective equipment is frequently lost unless it fits properly.

Poor Playing Surface. Some of the fields on which high school football is played in this state are appalling. This is especially true during the latter half of the football season when most of the turf has been worn away. Holes, ruts, ridges and other surface irregularities are obvious hazards. A number of fields are poorly crowned resulting in poor drainage.

Shoe Selection. Dr. Joseph Torg of Temple University has done a most excellent study of the relative safety of multiple shoe-surface combinations. His studies reveal that the shoe most commonly used by our state high school football players on grass is the least safe as regards knee injuries. The shoe which his studies found to be most safe is not used.

Poor Conditioning. This is felt to be a significant factor contributing to certain injuries primarily during the early part of the season. Also, players who begin heavy practice sessions on hot summer days, when the season begins, are much more prone to heat illness unless they are pre-conditioned.

Inadequate Rehabilitation. A large number of injuries are actually reinjuries, that is, superimposed on a previously injured extremity. This is extremely common as regards the knee. Following an initial episode of trauma, the extremity was not maximally rehabilitated prior to resuming competition. This often exposes an unstable joint controlled by atrophic muscles to stress which unquestionably invites reinjury and often results in compounding the original injury.

Absence of Medical Care. All players prior to competing in high school football must have a pre-season physical examination. A number of high school teams have no organized medical care beyond this stage. It is common to obtain a history from a high school athlete that he was injured in a game, came out of the game for several plays, was not evaluated medically, and returned to competition only to be reinjured. It is also common for a player to have been injured severely enough to be unable to continue playing, experience significant disability for several weeks during which his symptoms slowly subside, return to athletic activity and competition

only to be reinjured, never having been medically evaluated during this time. The great majority of injured high school football players are referred to our office by their coaches, not by physicians.

Methods of Improvement

Adequate Equipment. This is an absolute necessity for obvious reasons. Each individual player must have a good helmet with face guard, mouth-piece, shoulder pads, hip pads, thigh pads and shoes. Previously damaged equipment should either be adequately repaired or discarded. Worn out equipment must be discarded and replaced.

Properly Fitted Equipment. It is most important that all gear fit properly with emphasis on the helmet, shoulder pads and shoes. Equipment fitting should be supervised carefully by someone trained in the nuances of equipment fitting.

Better Playing Surface. The time of year for assuring a good football playing field is in the spring. The surface should be made as uniform and even as possible with proper crowning to provide good drainage. Reseeding and resodding of the surface should be carried out where necessary.

Every effort must be made to restrict use of the playing field. Ideally, the field should be used only for occasional scrimmages, a light work out the day before a game, and for scheduled games. Such activities as daily practice sessions, physical education classes and band practice should be carried out on another area.

Use of the Safest Shoe. According to the study carried out by Doctor Torg, the molded sole soccer-type shoe with 15 cleats, ⅜ inches long with ½ inch tip diameter, is the safest on any surface under all conditions.

Pre-Season Conditioning Program. This should be begun at least four weeks prior to the beginning of practice. Practice sessions should be devoted to teaching the skills of football and for the players to learn to execute as a team. Practice sessions should not be designed to "get players into shape"; keep them in shape, yes, but not "get them in shape." Players are less likely to get hurt while in the best physical condition and also are less likely to get hurt if they know what they are doing.

Players should spend at least one hour a day in a pre-season conditioning program. This can be divided into 20 minutes of proper weight lifting, 20 minutes in doing agility drills, and 20 minutes running wind sprints.

Maximum Rehabilitation Before Resuming Activity. This is mandatory before exposing a previously injured extremity to stress. A joint must have a pain free functional range of motion, no effusion and good stability. All involved muscle groups must rate excellent before competition is resumed. Schools need to provide only whirlpool and progressive resistance weight facilities. More sophisticated physical therapy modalities are unnecessary.

Medical Care. No high school in the State of West Virginia should be allowed to participate in a competitive athletic program without the services of a team physician. The physician should take all necessary steps to insure maximum player safety, including the following:

1. Each athlete upon entering high school should undergo and pass a thorough physical examination to include a CBC, urinalysis, chest x-ray, and a sickle cell test for blacks before being allowed to participate athletically.

2. Maximal rehabilitation of all post-injury and postoperative athletes must be carried out prior to resuming athletic activity.

3. Significantly injured players must be evaluated medically and proper definitive treatment begun as soon as possible.

4. The physician himself or a qualified designated replacement should be present for all home games.

5. The physician himself or a qualified designated replacement should be available daily during the season.

6. The physician should make sure that adequate protective equipment is worn and that it fits properly.

Discussion

The incidence and the severity of high school football injuries in the State of West Virginia can be reduced further. The solutions are certainly within our reach and will obviously require several avenues of approach.

Our high school athletic teams must have adequate medical coverage. High school coaches should not be saddled with any medical responsibility other than prohibiting a player just injured from resuming activity until seen by a physician. Certainly coaches should not make decisions as to whether a player can continue playing following injury. They should not have the responsibility of taping, supervising equipment fitting or supervising rehabilitation. These functions belong to the medical profession and we must assume them.

We are now in an era where consolidation of

high schools is becoming more common. In addition to having a team physician, these schools should hire a Certified Athletic Trainer. The trainer and physician together should be responsible for implementing an adequate medical program for the athletes.

The trainer, under the supervision of the physician where necessary, would be responsible for all taping, equipment fitting, rehabilitation, treatment of minor injuries, and for supervising a pre-season conditioning program. He would be present at all practice sessions and all games, home and away.

The proper administrative authorities must provide sufficient funds to insure good equipment and a well-kept acceptable playing surface and practice area.

Conclusions

1. Both the incidence and the severity of high school football injuries can be further reduced in the State of West Virginia.

2. By default, high school coaches assume medical responsibility for their athletes which should be assumed by a physician.

3. No high school in the State of West Virginia should be allowed to participate in competitive football without the services of a team physician.

4. It is strongly recommended that Certified Athletic Trainers be hired in our state high schools.

5. The molded sole soccer style football shoe containing 15 cleats, each ⅜ inches long with ½ inch cleat tip diameter should be worn by all high school football players.

A list of references may be obtained by writing The Journal.

Manuscript Information

Manuscripts to be presented for publication in *The West Virginia Medical Journal* should be typewritten, triple-spaced, on one side only of firm (not onion skin or flimsy), standard letter sized (8½ by 11 in.) white paper. Wide margins (at least 1¼ in. on left) should be left free of typing. On the first or title page should be shown the title of the article, the name (or names) of the author, and his degrees. Pages should be numbered consecutively, the page number being shown in the right upper corner along with the surname of the author.

Authors are requested to submit a carbon copy with the original or retain same in the event the manuscript is lost in transmittal.

Illustrations should be numbered and their approximate locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for cuts should be done in black (India) ink on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it. The author will bear the cost of all over two one-column halftone cuts.

All scientific material appearing in *The Journal* is reviewed by the Editorial Board. Manuscripts should be mailed to The Editor, West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

X-Ray Case of the Month

Black Lung (C. W. P.)

Murray B. Hunter, M. D., Fairmont; and Ray A. Harron, M. D., Bridgeport

Murray B. Hunter, M. D., Internist:

This 61-year-old male presented himself in July 1963 complaining of dyspnea on mild exertion (walking on the level ground) and shoulder pain. As part of his work-up, x-rays were taken of the shoulder showing calciferous deposits but no arthritis. Extensive work-up over the years has never revealed any evidence of rheumatoid arthritis or tuberculosis. A chest film was also taken at this time.

Ray A. Harron, M. D., Radiologist:

PA chest film (Figure 1) shows a noncalcified density approximately 3 cm. in diameter in the right upper lobe and a similar lesion 1 cm. in diameter in the left upper lobe. There are numerous smaller densities throughout both lung fields. It is felt that this represents simple and complicated pneumoconiosis and the film is classified 3/3qA.

Doctor Hunter:

Occupational history revealed that the patient was a coal miner since 1926 working mostly at the face and mostly on cutting and mining machines. He smoked less than one-half pack of cigarettes per day but recently had stopped because of the dyspnea. He was advised to stop mining, which he did, and he subsequently received a silicosis award from the state, and years later a black lung award from the federal government.

The patient's complaints did not vary much over the years; he was followed at 6 to 12 month intervals and x-ray films were usually taken on these visits.

Doctor Harron:

Representative films are reproduced here. In the January 1965 film (Figure 2) the large conglomerate nodule in the right upper lobe and the smaller one in the left upper lobe have in-

Figure 1

Figure 2

Figure 3

Figure 4

creased in size and the film could now be classified 3/3qB. By June 1968 (Figure 3) there are multiple large nodules, the largest one in the right upper lobe is moving into the hilar area. The film could now be classified 3/3qC. This is truly progressive massive fibrosis.

Doctor Hunter:

In 1969 the patient coughed up about a pint of black-ink-like sputum.

Doctor Harron:

The chest x-ray (Figure 4) now demonstrates cavitation in the conglomerate nodules in the right mid-lung and in the left upper lobe. These are felt to be cavitating areas of fibrosis not tuberculosis, abscess or tumor. In fact, five years later the film has not changed much.

Doctor Hunter:

This case represents an 11-year follow up of coal workers pneumoconiosis. Despite the fact that the patient was totally removed from his coal dust environment, despite the fact that he stopped smoking, despite the fact that repeated workups for tuberculosis or rheumatoid arthritis were negative, the pneumoconiosis progressed from a complicated A, through B, C and on to cavitation. It further demonstrates the only pathognomonic symptom of Coal Workers Pneumoconiosis (C.W.P.)-ink-black sputum.

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In congestive heart failure...

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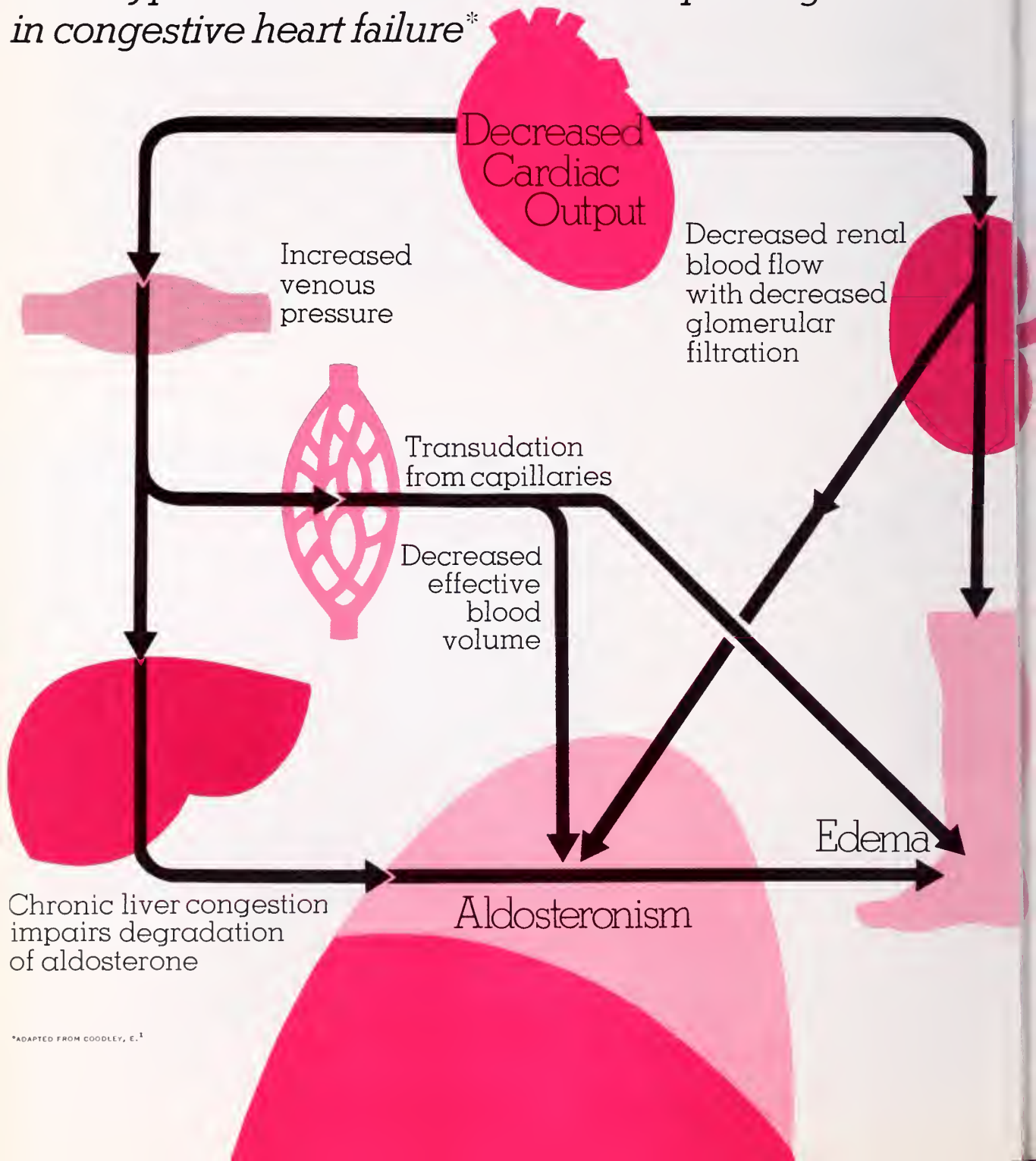
*How hyperaldosteronism leads to and prolongs edema in congestive heart failure**



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- Produces gradual, sustained diuresis by blocking aldosterone action in the distal renal tubule.
- Avoids potassium loss.

2. As the basic daily diuretic with an "add-on" alternate-day-diuretic ("A.D.D." schedule)

- Can be administered daily as basic therapy with the additional agent (furosemide or ethacrynic acid) given every second or third day.
- Aldactone plus "A.D.D." schedule minimizes potassium deficiency and potentiates effect of "add-on" diuretic.[2]
- Avoids acute volume depletion and aldosterone rebound.[2]

3. As a daily diuretic in combination with a daily dose of a thiazide

- Permits daily additive diuretic effect while maintaining potassium balance.

Indications—Essential hypertension; edema or ascites of congestive heart failure, cirrhosis of the liver and the nephrotic syndrome; idiopathic edema. Some patients with malignant effusions may benefit from Aldactone (spironolactone), particularly when given with a thiazide diuretic.

Contraindications—Acute renal insufficiency, rapidly progressing impairment of renal function, anuria and hyperkalemia.

Warnings—Potassium supplementation may cause hyperkalemia and is not indicated unless a glucocorticoid is also given. Discontinue potassium supplementation if hyperkalemia develops. **Usage of any drug in women of childbearing age requires that the potential benefits of the drug be weighed against its possible hazards to the mother and fetus.**

Precautions—Patients should be checked carefully since electrolyte imbalance may occur. Although usually insignificant, hyperkalemia may be serious when renal impairment exists; deaths have occurred. Hyponatremia, manifested by dryness of the mouth, thirst, lethargy and drowsiness, together with a low serum sodium may be caused or aggravated, especially when Aldactone is combined with other diuretics. Elevation of BUN may occur, especially when pretreatment hyperazotemia exists. Mild acidosis may occur. Reduce the dosage of other antihypertensive drugs, particularly the ganglionic blocking agents, by at least 50 percent when adding Aldactone since it may potentiate their action.

Adverse Reactions—Drowsiness, lethargy, headache, diarrhea and other gastrointestinal symptoms, maculopapular or erythematous cutaneous eruptions, urticaria, mental confusion, drug fever, ataxia, gynecomastia, inability to achieve or maintain erection, mild androgenic effects, including hirsutism, irregular menses and deepening voice. Adverse reactions are infrequent and usually reversible.

Dosage and Administration—For **essential hypertension** in **adults** the daily dosage is 50 to 100 mg. in divided doses. Aldactone may be combined with a thiazide diuretic if necessary. Continue treatment for two weeks or longer since an adequate response may not occur sooner. Adjust subsequent dosage according to response of patient.

For edema, ascites or **effusions** in **adults** initial daily dosage is 100 mg. in divided doses. Continue medication for at least five days to determine diuretic response; add a thiazide or organic mercurial if adequate diuretic response has not occurred. Aldactone dosage should not be changed when other therapy is added. A daily dosage of Aldactone considerably greater than 75 mg. may be given if necessary.

A glucocorticoid, such as 15 to 20 mg. of prednisone daily, may be desirable for patients with extremely resistant edema which does not respond adequately to Aldactone and a conventional diuretic. Observe the usual precautions applicable to glucocorticoid therapy; supplemental potassium will usually be necessary. Such patients frequently have an associated hyponatremia—restriction of fluid intake to 1 liter per day or administration of mannitol or urea may be necessary (these measures are contraindicated in patients with uremia or severely impaired renal function). Mannitol is contraindicated in patients with congestive heart failure, and urea is contraindicated with a history or signs of hepatic coma unless the patient is receiving antibiotics orally to "sterilize" the gastrointestinal tract.

Glucocorticoids should probably be given first to patients with nephrosis since Aldactone, although useful for diuresis, will not directly affect the basic pathologic process.

For **children** the daily dosage should provide 1.5 mg. of Aldactone per pound of body weight.

References: 1. Coodley, E. Consultant 12 106-107, 109, 111, 113, 115 (July) 1972. **2.** Thorn, G. W., and Lauler, D. P.: Am. J. Med. 53 673-684 (Nov.) 1972.

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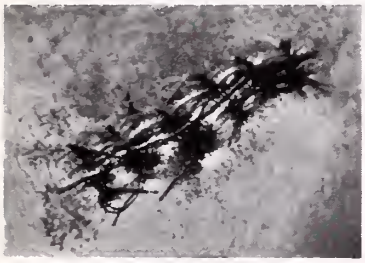

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THE PROGRAM will offer a wide-ranging clinical and educational experience for the physician. On FRIDAY MORNING there will be a round-table conference concerning psychiatric problems in the aging and recognition and management of spasticity. FRIDAY AFTERNOON such subjects as hypertensive therapy, treatment of peptic ulcer, pacemakers and birth control pills will be discussed. Sectional conferences will open SATURDAY MORNING'S session, with lectures on rectal cancers and major burn therapy, followed SATURDAY AFTERNOON by a round-table conference with reference to antibiotics in the critically ill patient and venereal disease.

THE FACULTY WILL INCLUDE:

Richard Herman, M. D., Temple University
Michael F. Michelis, M. D., University of Pittsburgh
Robert W. Kellermeyer, M. D. University Hospitals of Cleveland
Charles E. Andrews, M. D. West Virginia University Medical Center
William J. Holloway, M. D., Wilmington Medical Center, Wilmington, Delaware
Hans A. Neumann, M. D. New Haven, Connecticut
Rupert B. Turnbull, M. D. Cleveland Clinic
Harvey Slater, M. D., West Penn Burn Center, Pittsburgh, Penna.

THE REGISTRATION FEE of $25.00 for the entire conference will be charged all registrants and will include admission to luncheon on Friday and Saturday and evening entertainment and dinner for the registrants **and** their wives on Friday **and** Saturday.

LADIES PROGRAM:

The Auxiliary of the Wheeling Clinic has arranged for tours (of the historic Oglebay Mansion House, Museum and Art Gallery; and, of a Handcraft Glass Plant) for those who are interested. Also, golf or tennis, plus plenty of "free" time.

OVERNIGHT ACCOMMODATIONS

Registrants are responsible for their own lodging at their choice of hotel or motels. A block of rooms is available (on a first-come first-served basis) at Wilson Lodge in Oglebay Park and you may contact Mr. **Russ Bond at 242-3000.**

--------Mail to: Golden Jubilee Committee, Wheeling Clinic, Wheeling, W. Va. 26003--------

Please register me for the Golden Jubilee Seminar of the Wheeling Clinic, October 18th and 19th. My registration fee of $25.00 is enclosed. I understand the registration is limited to One Hundred Physicians.

Name:_____ Specialty:_____
(Please Print)

Address:_____ City:_____ State:_____

My wife _____will attend
_____won't

Phone:_____ Zip Code:_____

A message from . . .

The President

THE ART OF ADVOCACY

It is my strong personal feeling that we as an Association should either endorse or condemn projects or plans for the delivery of health care. On important public issues we should have a position that we can promote or defend. Our position should be based upon how we have founded our professional lives—our patients' welfare.

On highly inflammatory issues, study, objective viewing of the total picture, and debate followed by a vote should determine our position. As an Association we could then crusade for our cause.

In many instances we have failed to address important issues. However, many of our members in their personal and professional lives have practiced the art of advocacy and I think to their patients' advantage.

The following doesn't pretend to be the complete list but merely a few outstanding examples:

Dr. Albert C. Esposito, whose zeal in promoting a medical school at Marshall, must be admired. He also led his party's ticket for the House of Delegates in the recent primary in Cabell County. Dr John T. Chambers, who more than anyone else, is responsible for the creation of CAMC and the WVU Medical School affiliation in Charleston. Dr. David E. Wallace of Madison, who at great personal sacrifice, served almost four years in the State Senate; and Drs. Milton J. Lilly and Roy A. Edwards, who each served two years in the House of Delegates. Dr. Harry S. Weeks, Jr., who helped to almost unseat the AMA hierarchy at the recent meeting in Chicago; Dr. Carl Hoffman, who refused to yield to the AMA brass while serving as President and Past President of the AMA; Dr. Carl B. Hall, who is running for the presidency of the AAFP; and yes, the late Dr. I. E. Buff who, more than anyone, is responsible for our State and national black lung laws; and Dr. Hawey A. Wells, Jr., who is running for the House of Delegates and who earlier waged a spirited campaign for Congress.

I don't necessarily agree with the positions of these men but at least they have a position—you know where they stand.

It really is possible to disagree without being disagreeable. We as an Association should take note.

See you at The Greenbrier!

Tom McCoy

A. Thomas McCoy, M. D., *President*

THE WEST VIRGINIA MEDICAL JOURNAL

Official Organ of the West Virginia State Medical Association

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Editor
GEORGE F. EVANS, M. D.
122 South Sixth St.
Clarksburg, W. Va.

Managing Editor and
Business Manager
MR. WILLIAM H. LIVELY
Box 1031
Charleston, W. Va. 25324

Associate Editors:
VERNON E. DUCKWALL, M. D.
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EDITORIALS

THE 107th

In just a couple of weeks Dr. A. Thomas McCoy will use the gavel to officially call to order the 107th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs. It hardly seems possible the months have passed so quickly since everybody said so-long—see you next year—at the conclusion of the 106th.

We believe the answer lies in the fact that many members of the Association have gone through a busy and oftentimes hectic year filled with numerous meetings in an attempt to cope with the many perplexing problems thrust upon us by the Federal Government as well as various third-party agencies. A feather should be placed in the cap of every member who voluntarily has devoted countless hours in helping to preserve the freedom of physicians to practice medicine in the best interest of their patients.

Although we realize the business agenda at The Greenbrier probably will be heavier than usual this year, let's turn our attention to the wonderful hours of rest and relaxation which have been set aside for us during the convention.

Prior to taking office last August, Doctor McCoy selected Dr. J. Hugh Wiley to serve as Chairman of the Program Committee for this year's meeting. From the outset, Doctor Wiley and the other members of the Committee decided that the format of the meeting should be changed to enable physicians, their families and guests to avail themselves of the finest in postgraduate medical education—as well as ample time to take advantage of the many recreational facilities at The Greenbrier.

A. Thomas McCoy, M. D., President

A glance at the program published elsewhere in this issue of *The Journal* indicates that physicians will have an opportunity to rise early, attend the breakfast section meetings of their choice and the general scientific sessions which will come to an end at noon each day. With few exceptions, the afternoon and evening hours have been left open. This procedure is innovative but we have an idea it will be most acceptable and perhaps set a precedent for future meetings.

The Program Committee has succeeded in lining up some of the most prominent physicians and surgeons in the country as speakers to pass along up-to-date information to help the physician in his daily practice. The difference? Instead of sitting in a meeting room during the afternoon hours there is a good chance they will have an opportunity to chat with these same speakers while looking for a lost golf ball on the golf course.

It will be a pleasure to have with us two distinguished honor guests who will speak at sessions open to physicians, members of the Auxiliary and other guests.

Dr. Malcolm C. Todd of Long Beach, California, President of the American Medical Association, will speak at the first session of the House of Delegates on Wednesday afternoon, August 21. Doctor Todd has been involved in the affairs of organized medicine for many years and has served as chairman of several key AMA committees prior to being elevated to the presidency. We are confident he will not allow anything to stand in his way to make sure the rights of practicing physicians are protected during his term of office.

Also, we look forward to the appearance of the Hon. Robert C. Byrd, United States Senator from West Virginia and Majority Whip of that august body. The Program Committee couldn't have selected a more respected gentleman to deliver the "Thomas L. Harris Address" at the opening scientific session on Thursday morning, August 22. We feel sure the late Doctor Harris would have been delighted with the decision to invite Senator Byrd.

His record in behalf of the citizens of West Virginia and the country is well known and results of his last victory in the 1970 senatorial election—78 per cent of the vote cast—tells the story of his popularity. He is truly a statesman carrying a heavy burden for the entire country—but, never one to delay responding to a phone call or letter from a constituent in his home State of West Virginia.

We would be remiss not to mention the hard work put forth by Doctor McCoy during his term of office. He has attempted to make good a pledge to "unite" the Federation of organized medicine in West Virginia as this was his main theme when he took office. A difficult task, to be sure.

Although he is reluctant to take credit for any exceptional accomplishments we believe he has succeeded in many respects. He has his own ideas—but don't we all! He carried his message to official meetings of almost every component society and has never minced words about what he believes is best for his colleagues and their patients. We're fortunate he will succeed to the position of Chairman of the Council during the coming year.

Dr. William E. Gilmore of Parkersburg will be installed as President of the Association at the final session of the House of Delegates on Saturday afternoon, August 24. Like his predecessors, Doctor Gilmore has a background of many years of hard work for the profession in West Virginia. His past service on the Council as well as a member and chairman of several important committees makes him highly qualified in what undoubtedly will be a crucial year to the practicing physicians of West Virginia.

We should all give a vote of thanks to the retiring Chairman of the Council, Dr. Worthy W. McKinney. He has managed in his quiet and persuasive manner to keep matters of deep concern in line with the best interests of the profession.

Let's not forget the important work of the members of the Woman's Auxiliary and their constant effort to assist their physician husbands—not to mention their participation in various projects to help citizens in communities throughout the State. Auxiliary members seldom receive credit they deserve for the many responsibilities they have assumed in past years.

Mrs. J. Dennis Kugel, the President, and her most efficient Board of Directors have worked diligently during the past year to stress the importance of involving additional wives of physicians in various activities of the Auxiliary.

Mrs. Kugel, as well as the other past presidents who preceded her in office, certainly deserve much credit for their tremendous work since the Auxiliary was organized 50 years ago. As usual, the Auxiliary will be in charge of the entertainment program at The Greenbrier and

the 50th Anniversary Ball in the beautiful new Colonial Hall is a function which everybody should plan to attend.

For the first time since the Convention Unit was completed in 1955 there will be no commercial exhibits on display. It was with much reluctance that the Council decided to discontinue the sale of exhibit space but finally found it necessary to do so due to the fact that the cost of labor, materials and other related expenses skyrocketed to the point where the Association lost money in keeping the Exhibit Center open.

We are happy and proud to report, however, that many of our loyal exhibitors have contributed grants to the Association to help support the scientific program this year. Representatives of these firms have been invited to attend and they have been extended a cordial invitation to visit with old friends and attend the social functions.

There will be a number of scientific exhibits prepared by State and volunteer agencies and they will be housed in a section of the new Colonial Hall which is adjacent to Chesapeake Hall where all general business and scientific sessions have been scheduled.

From all indications, it seems certain that this year's annual meeting will go down as one of the best in the long history of the Association and we hope you plan to attend.

We'll see you at The Greenbrier!

SUICIDE RATE AMONG PHYSICIANS

It is believed by many that physicians have a high suicide rate. Figures have been published which indicate that physician suicide rates were three times that of white - collar workers; however, more moderate figures have also appeared. One study indicated that the suicide rate was only 1.5 times as great. Some of these studies have been questioned; for example, it has been pointed out that the suicide of a physician often receives much more publicity than that of the average layman.

Recently an excellent article by Steppacher and Mausner[1] appeared which concerned suicide rates in male and female physicians. The data were obtained through the obituary listings in the *Journal of the American Medical Association*. The period studied was from March 1965 to August 1970, a span of five and one-half years. During this interval 530 deaths by suicide were identified, 489 men and 41 women. When these data were carefully analyzed, the suicide rate in male physicians was found to be approximately 1.15 that of the overall population, whereas the rate for female physicians was fully three times of that expected on the basis of population values.

Several interesting factors were brought out in the study of Steppacher and Mausner. One concerned the most frequent age at which male and female physicians committed suicide. Figures distinctly showed that there was an excess of suicides among male physicians in the middle years of life, that is, between the ages of 45 and 64. Elderly male physicians had a relatively low suicide rate. The authors suggest possible reasons for the excess of suicides among middle-aged physicians, such as mental depression induced by a sense of failure to achieve early goals, of unused opportunities, and constricting potential for the future. It seems that another factor might be suggested, namely that some of them knew they were suffering from an incurable illness and did not wish to face months of suffering and invalidism. Be all that as it may, it is indeed unfortunate that so many relatively young physicians commit suicide, some of them at the height of their powers and capable of rendering valuable services to their community.

The data also clearly indicated that female physicians committed suicide relatively early in life, that is, before the age of 44 years. This is a great pity for there are many opportunities in various fields of medicine for women. It is indeed unfortunate that these women who had gained a splendid education and who were well equipped to render a high grade professional service, ended their career at such an early period of life. This entire matter should be studied carefully and every effort made to prevent these outstanding women from taking their own lives.

The prevention of suicide, even in those cities which have suicide-prevention centers, has not been as helpful as one would desire. Much more work remains to be done. Suicide continues to rank as a very important cause of death. The prevention of suicide is not alone the responsibility of the psychiatrist, but rather the responsibility of every physician. It is the task of all physicians to attempt to prevent self-destruction.

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1. Steppacher, R.C. and Mausner, J.S. JAMA. 228: 323, 1974.

GENERAL NEWS

Senator Byrd And Dr. Malcolm Todd Headliners For Annual Meeting

Sen. Robert C. Byrd of West Virginia and Dr. Malcolm C. Todd of Long Beach, California will be featured speakers during the 107th Annual Meeting of the West Virginia State Medical Association this month.

Doctor Todd was installed as the American Medical Association's 129th President in June. He will address the first session of the Association's House of Delegates at 2:30 P. M. on Wednesday, August 21—opening day for the Annual Meeting at The Greenbrier in White Sulphur Springs.

Senator Byrd will deliver the second annual "Thomas L. Harris Address" as the keynote speaker for 9 A. M. opening exercises on Thursday preceding the first general scientific session. This session and all other scientific sessions will be held in Chesapeake Hall this year instead of Governor's Hall as in former years.

The Annual Meeting will continue through Saturday afternoon, August 24, when Dr. William E. Gilmore, Parkersburg surgeon, will be installed as Association President during the second and final session of the House of Delegates. Doctor Gilmore will succeed Dr. A. Thomas McCoy of Charleston as President.

Doctor Todd, a general surgeon, is a native of Carlyle, Illinois. He received degrees from the University of Illinois and Northwestern University before receiving his M. D. degree in 1938 from Northwestern. He is considered one of the nation's foremost authorities on health manpower needs and has served twice as Chairman of the AMA's Council on Health Manpower.

A Diplomate of the American Board of Surgery, Doctor Todd also is a Fellow of the American College of Surgeons, the International College of Surgeons, the American College of Gastroenterology and the Royal Society of Medicine.

From 1959 until being named President Elect of the AMA, he was a member of the California delegation to the AMA House of Delegates. He was President of the California Association in 1968-69.

Senator Byrd, a native of Sophia, in Raleigh County, was elected Majority Whip of the United States Senate in 1971 and was unanimously reelected in 1973. He served two terms as a member of the West Virginia House of Delegates and one term as a member of the State Senate. In 1952, he was elected to the first of three terms as a member of the U. S. House of Representatives and has served as one of two West Virginia members of the United States Senate since 1958.

He was elected Secretary of the Senate Democratic Conference in 1967 and also serves as a member of the Appropriations Committee, Judiciary Committee and the Committee on Rules and Administration.

Senator Byrd was graduated cum laude with a J. D. degree from the American University. He has held more legislative elective offices than any other individual in West Virginia history.

Presidential Address

Doctor McCoy, who is a urologist in Charleston, will deliver his address as the retiring Association President prior to the installation of Doctor Gilmore at the final House session on Saturday afternoon.

Pre-Convention Meetings

The Association's Council will have a pre-convention meeting at 10 A. M. on Wednesday, August 21.

Malcolm C. Todd, M. D.

Convention Timetable

The first general scientific session will begin at 9 A.M. on Thursday, August 22. The Friday session will begin at 9:30 A.M., and the session on Saturday, also at 9:30 A.M.

The first session of the House of Delegates will be on Wednesday afternoon, August 21, beginning at 2:30 o'clock. The second session will be on Saturday afternoon beginning at 2:30 o'clock.

Its Chairman, Dr. Worthy W. McKinney of Beckley, will preside. The first House session will follow in Chesapeake Hall at 2:30 P. M. Doctor McCoy will be presiding officer.

From 6:30 to 7:30 P. M. on Wednesday, a President's Reception for Honor Guests will be held on the Chesapeake Hall Terrace.

General Scientific Sessions

As noted, all three of this year's general scientific sessions will be held in Chesapeake Hall, with the first at 9:45 A. M. on Thursday, August 22. The other two sessions will be at 9:30 A. M. on Friday and Saturday.

An innovation at this year's convention will be breakfast meetings of sections and affiliated societies of the Association. Many of the guest speakers have accepted invitations to present talks at the breakfast meetings, which were scheduled to enable physicians and members of their families to enjoy the recreational facilities of The Greenbrier during the afternoon hours.

Another change this year will be the location of the scientific exhibits, which will be the new Colonial Hall which has been built immediately adjacent to Chesapeake Hall.

Formal Opening Exercises

Doctor McCoy will call the Annual Meeting to order at the 9 A. M. session on Thursday, with Dr. Joseph T. Skaggs of Charleston to give the invocation. Doctor McCoy will make welcoming remarks and Dr. J. Hugh Wiley of Morgantown, the 1974 Program Committee Chairman, will be introduced. The first general scientific session will be held following the address by Senator Byrd.

Dr. Philip M. Sprinkle of Morgantown, a member of the Program Committee and Chairman of the Division of Otolaryngology at the West Virginia University School of Medicine, will serve as Moderator for the "Symposium on Newer Concepts in Infectious Diseases." The speakers and their subjects will include:

Dr. Albert S. Klainer and Robert W. Veltri, Ph. D., members of the WVU faculty, "Current Immunization Mechanisms;" Dr. Louis Weinstein, Chief of the Division of Infectious Diseases and Professor of Medicine at Tufts University School of Medicine in Boston, "Effects of Antibiotics on Changing Spectrum of Infection;" Dr. Charles H. Kirkpatrick, from the National Institute of Allergy and Infectious Diseases in Bethesda, Maryland, "Immunotherapy of Chronic Infectious Diseases;" and Dr. Virgil M. Howie of Huntsville, Alabama, a pediatrician, "Acute Otitis Media."

Thursday Afternoon And Evening

The Association's Resolutions Committee, with Dr. Richard E. Flood of Weirton presiding, will meet at 2 P. M. Thursday in the West Virginia Room. At 7:30 P. M., there will be a dinner honoring Past Presidents of the Association in the Fillmore-Van Buren Rooms. Dr. Worthy W. McKinney of Beckley will preside.

Friday Breakfast Meetings

The Friday morning breakfast meetings will begin at 8 o'clock. The meetings, speakers (where scheduled) and their topics are as follow:

West Virginia Academy of Ophthalmology and Otolaryngology, Washington Room, Virginia Wing;

Section on Internal Medicine, Dr. Harold Selinger of Charleston, presiding; Panel to include Drs. Weinstein, Kirkpatrick and Robert F. Schilling, Washburn

Dinner for Past Presidents

A dinner honoring Past Presidents of the West Virginia State Medical Association and their wives will be held at The Greenbrier on Thursday evening, August 22, during the 107th Annual Meeting.

Dr. Worthy W. McKinney of Beckley, Immediate Past President, will preside, and invitations have been extended to all the Association's living Past Presidents and their wives.

Sen. Robert C. Byrd

William E. Gilmore, M. D.

Professor of Medicine, University of Wisconsin Medical School, Madison; Lee Room, Virginia Wing;

Section on Neurology, Neurosurgery and Psychiatry; Speaker, Albert J. Azzaro, Ph. D., Assistant Professor of Neurology and Pharmacology, WVU, "Brain Catecholamines and Affective Brain Disorders," Pierce Room;

Section on Orthopedic Surgery, Dr. Robert W. Lowe of Huntington, presiding; Speaker, Dr. Allen H. Mackenzie, Staff Member of the Division of Medicine, Department of Rheumatic Disease, Cleveland Clinic Foundation, "Efficacy Versus Safety of Potent Rheumatologic Drugs," Buchanan Room;

Sections on Urology and Surgery, Drs. Harold N. Kagan and Alvin L. Watne, presiding; Speaker, Dr. James F. Glenn, Professor and Chief of the Division of Urologic Surgery, Duke University Medical Center, "Stress Incontinence," Jackson Room;

House of Delegates To Meet Twice During Meeting

The first session of the House of Delegates during the Annual Meeting at The Greenbrier will be convened at 2:30 P.M. on Wednesday, August 21. The second and final session of the House of Delegates will be held at 2:30 P.M. on Saturday, August 24.

West Virginia Radiological Society, Dr. Joseph M. Aceto of Wheeling, presiding, business meeting, Director's Room.

Second General Session

Dr. Winfield C. John of Huntington will be the Moderator at the second general scientific session beginning at 9:30 A.M. on Friday, with speakers and their topics to include:

Drs. Glenn, "Surgical Causes of Hypertension;" Mackenzie, "Diagnosis of Arthritis and Rheumatism in Children;" and Schilling, "The Logical Approach to Anemia."

Schedule For Friday Afternoon

The Association's Cancer Committee will meet at 12:15 P. M. Friday in the Main Dining Room, with Doctor Watne presiding.

The West Virginia Chapter of the American Academy of Pediatrics will meet at 2 P. M. in the Fillmore Room. The guest speaker, Doctor Howie, will discuss "Recurrent Acute and Serous Otitis Media." Dr. Barbara Jones of Morgantown will preside.

Scheduled for 4 o'clock are meetings of the West Virginia Chapter of the American Society of Internal Medicine, with Dr. Leo H. T. Bernstein presiding, in the Jackson Room, and the West Virginia District Branch of the American Psychiatric Association, with Dr. Thomas S. Knapp presiding, in the Director's Room. The Association's Committee on Nominations will meet at 5 P. M. in the Lee Room, Virginia Wing, with Dr. Harry S. Weeks, Jr., of Wheeling, presiding.

Saturday Morning Session

A discussion of the "Department of Family Practice at the WVU School of Medicine" will begin the third general scientific session at 9:30 A. M. Saturday. The speaker will be Dr. John W. Traubert, Chairman of the Department. Dr. Ray M. Kessel will be Moderator.

The remainder of the morning program will be devoted to a Symposium on "What Are the Barriers to an Improved Medical Practice in West Virginia?" The floor will be open for discussion of all questions physicians believe need to be answered concerning such subjects as PSRO, malpractice insurance, etc. Doctor Wiley will be the Moderator.

Second House Of Delegates Session

Doctor McCoy again will be the presiding officer at the second and final House of Delegates Session in Chesapeake Hall at 2:30 P. M. on Saturday.

Along with his Presidential Address and the installation of Doctor Gilmore, the agenda will include election of other Association officers and consideration of several resolutions and other business items.

Medical School Alumni Events

The West Virginia University School of Medicine's Alumni Association; the University of Virginia Medical School Foundation, and the West Virginia Chapter, Medical College of Virginia Alumni Association, will hold cocktail parties on Thursday evening, August 22.

The 1974 Program Committee

Dr. J. Hugh Wiley of Morgantown is Chairman of the Program Committee for the 107th Annual Meeting of the West Virginia State Medical Association. Other members of the Committee are Drs. John T. Chambers of Charleston, William E. Gilmore of Parkersburg, Winfield C. John of Huntington, Ray M. Kessel of Logan and Philip M. Sprinkle of Morgantown.

Doctor Clark K. Sleeth will be in charge of the WVU festivities in the West Virginia Room at 6 P. M., with Dr. E. L. Crumpacker of White Sulphur Springs in a similar role for the University of Virginia affair at the same hour. Dr. Carl J. Roncaglione of Charleston will be in charge of the Medical College of Virginia event at 6:30 P. M. in the Old White Club.

Friday Night Auxiliary Dance

The 50th Anniversary Ball will be sponsored by the Woman's Auxiliary to the State Medical Association at 10 P. M. Friday in the new Colonial Hall. The Raleigh County Auxiliary, with Mrs. R. James Yates of Beckley serving as Chairman, will host the dance.

Saturday Evening Reception

New officers of the State Medical Association will be honored at a cocktail party and reception from 6:30 to 7:30 P. M. Saturday on the Chesapeake Hall Terrace. All members of the Association and Auxiliary and their families, representatives of scientific exhibitors and convention guests are cordially invited.

Scientific Exhibits

Another departure from previous conventions will be the absence of industrial exhibits this year. Physicians, members of the Auxiliary and their guests, however, are urged to visit the interesting scientific exhibits which will be housed in Colonial Hall, as noted. The exhibits will be open from 8:30 A. M. to the close of the morning sessions.

Advance registration for the Annual Meeting at The Greenbrier, in keeping with the recent trend, has been heavy. As this issue of The Journal went to press, more than 600 persons had made reservations.

No Registration Fee for Members

Members of the West Virginia State Medical Association will not be assessed a registration fee in connection with the 107th Annual Meeting at The Greenbrier in White Sulphur Springs, August 21-24.

Interns, residents and medical students also will be registered without charge.

There will be a registration fee of $50 for out-of-state physicians attending the meeting.

Nominating Committee to Meet On Friday, Aug. 23

The State Medical Association's Committee on Nominations will hold a 5 P.M. meeting on Friday, August 23, in the Lee Room of The Greenbrier.

The Committee will make nominations to the House of Delegates for President Elect, Vice President and Treasurer, and for Delegate and Alternate Delegate to the American Medical Association.

Association By-Laws also provide that nominations may be made from the floor for these offices, to be filled by the House in balloting at its final session on Saturday, August 24, the final day of the Association's 107th Annual Meeting.

Dr. Harry S. Weeks, Jr., of Wheeling, will serve as Chairman of the Committee on Nominations, with other members to include: Drs. Robert G. Janes, Fairmont; Robert R. Pittman, Martinsburg; L. H. Nefflen, Elkins; F. Lloyd Blair, Parkersburg; Harold N. Kagan, Huntington; Richard G. Starr, Beckley; and Thomas P. Long, Man.

In addition, one of the Kanawha Medical Society's two Councilors will serve on the Committee under provisions of the By-Laws, but that representative had not been announced as this issue of The Journal went to press.

'Golden Jubilee' Seminar Planned By The Wheeling Clinic

The Wheeling Clinic will celebrate its "Golden Jubilee" in the form of a Scientific Seminar in Medicine and Surgery at Oglebay Park in Wheeling, October 18-19.

The two-day seminar will offer a wide ranging clinical and educational experience for physicians. A number of distinguished physicians and surgeons have accepted invitations to participate as speakers at the scientific sessions and round-table conferences.

The Auxiliary of the Wheeling Clinic has arranged tours of various features at Oglebay Park and other interesting spots in the Wheeling area. Ample time has been alloted for recreational activities.

The meeting has been approved for 12 hours credit by the American Academy of Family Physicians and the registration fee for the the entire conference is $25. Registration will be limited to 100 physicians.

Additional information concerning the seminar may be found on Page 185 in this issue and additional details will be published in the September and October issues of The Journal.

New Sports Activities Scheduled During Annual Meeting

Golf and tennis tournaments for physicians and their wives attending Annual Meetings of the State Medical Association at The Greenbrier have been traditional.

This year, however, fishermen will have an opportunity to vie for an "angler's award" and riflemen will take aim at several trophies in a skeet shooting tournament.

An outline of the sports activities follows:

Golf: Dr. Joseph A. Smith of Dunbar is in charge of the Men's Medical Golf Tournament. He announced that there will be a $5.00 registration fee and competing physicians may play their rounds during any morning or afternoon on Thursday through Saturday, August 22-24. Specific starting times and other rules will be in effect with this year's golf play and those planning to take part should make sure they are familiar with those rules.

Competitors must inform the starter when they begin their official 18 holes of play. All tournament play must be completed by 4 P. M. on Saturday to permit the awarding of prizes during an evening reception honoring new officers of the State Medical Association. Dr. George A. Curry of Morgantown will be out to defend the championship which he won in 1973 by a margin of one stroke.

Mrs. Charles S. Harrison of Clarksburg is Chairman of the Auxiliary's Golf Tournament which is scheduled for Friday afternoon, August 23.

Tennis: Dr. Harold Selinger of Charleston will serve as Chairman of the Men's Tennis Tournament for physicians and Mrs. Thomas J. Janicki, also of Charleston, will be Chairman for the Auxiliary Tournament. Completion in both tournaments will be limited to doubles and those interested in playing should register at the Pro Shop at the tennis courts.

Skeet: Dr. O. M. Harper of Clendenin will be in charge of the Skeet Shooting Tournament. He said trophies will be awarded to winners in the 12 gauge and 20 gauge competition. He has advised interested physicians to furnish their own rifles and there will be no registration fee.

In the official competition physicians will be allowed to fire 50 shots with each gun.

Fishing: Another innovation at this year's meeting will be the annual "Carl J. Roncaglione Fishing Tournament." Doctor Roncaglione will be in charge of the tournament and he has indicated there will be no restrictions on the type of fish, or the whereabouts of its catch so long as it is in the immediate vicinity of The Greenbrier. The competition is for physicians or members of physicians' families in attendance at the meeting. All lakes and streams and trout ponds in the immediate and adjacent counties qualify as acceptable fishable bodies of water. There is no limit on the type of tackle or bait used. For obvoius reasons, the management at the hotel discourages fishing in the golf course lakes except after dark.

Doctor Roncaglione said he would be available to witness and record all catches entered in the hope of winning the "angler's award," which will be in the form of a trophy. The winning requirement will be fulfilled by a factor produced by multiplication of the length in inches times the girth in inches of any and all fish entered in the contest. The highest factor will be the winner. Contestants wishing to enter fish in the contest have been asked to contact Doctor Roncaglione at the hotel to establish their entry.

Four Continuing Medical Education Programs In State Accredited

The continuing education programs of two hospitals and two specialty organizations were accredited on July 14 by the State Medical Association's Committee on Medical Education and Hospitals, which met in Charleston.

Receiving full three-year accreditation were Beckley Appalachian Regional Hospital, the West Virginia Academy of Ophthalmology and Otolaryngology and West Virginia Chapter, American College of Surgeons.

The Veterans Administration Center at Martinsburg received a two-year provisional accreditation for a newly developing program.

The accreditation period was effective retroactively to June 17 for Beckley Appalachian Regional Hospital while July 14 was the effective date for the other hospital and the two specialty organizations. The Beckley hospital was given a one-year provisional accreditation in June of 1973.

The four continuing medical education programs now qualify for Category 1 credit toward the Physician's Recognition Award of the American Medical Association, meaning that physicians attending these programs may claim hour-for-hour credit toward the Award in category 1 (AMA-approved programs).

Accreditation of CME programs is based on information obtained from a pre-survey questionnaire and the recommendation of a site survey team, all conducted under the supervision of the Committee on Medical Education and Hospitals with the assistance of the State Medical Association staff. A hospital or organization must request an accreditation survey.

Latest News From Nationwide Concerning Medicare Charges

Since the expiration of Economic Stabilization Program controls, Nationwide's Medicare operation in Columbus has prepared the necessary reasonable charge screens for Medicare services based on billed charges for services incurred in calendar year 1973.

After inspection by the Regional Health Insurance Office, it is planned to implement these new reasonable charge screens for claims received on or after July 1, 1974.

Patient-Type Questions To Be Part Of Heart Meeting's Approach

"Coronary Heart Disease — Modern Evaluation and Treatment" will be the theme of the Scientific Session during the 1974 Annual Meeting of the West Virginia Affiliate of the American Heart Association September 27 and 28.

The site will be Wilson Lodge at Oglebay Park in Wheeling.

The Scientific Session will be from 9 A.M. to Noon on Saturday, September 28.

Dr. Michael F. Wilson of Morgantown, President of the State Affiliate, said he believes the Scientific Session will be an "outstanding opportunity for the practicing physician to participate in and hear the most up-to-date and expert opinion on coronary heart disease. One of the more interesting features of the Saturday morning presentation is that the panel of doctors will address their attention to the kinds of questions which the patient asks the physician in his office, and questions which the physician wants answered from his consultant.

Michael F. Wilson, M. D.

"We are using the grand rounds approach with presentation of the concept, clinical examples and a discussion period for five separate but interrelated topics."

The panel will include Drs. Creel S. Cornwell of Clarksburg, Murray B. Hunter of Fairmont, Harold Selinger of Charleston and, from the West Virginia University School of Medicine, Drs. Allen F. Bowyer, Abnash C. Jain, David Z. Morgan and Thomas J. Tarnay. Dr. Nanette K. Wenger of Atlanta will be a special guest panelist. Doctor Wenger is Professor of Medicine (Cardiology) at Emory University School of Medicine, and Director, Cardiac Clinics, Grady Memorial Hospital in Atlanta.

Registration will begin at 10 A.M. on Friday, September 27, with the General Assembly convening at 2 P. M. The keynote address will be delivered by Dr. Leo H. T. Bernstein of Martinsburg, President-Elect.

Doctor Wenger will address the annual membership banquet Friday evening.

Ross Reid of New York City, Chairman of the Board of the American Heart Association, will speak at the Awards Luncheon on Saturday. This will be followed by panel discussion groups and the second General Assembly in the afternoon. The program will conclude with a Board of Directors dinner meeting Saturday evening.

House of Delegates To Take Action On Constitutional Amendment

One amendment to the Constitution of the West Virginia State Medical Association, offered at the 106th Annual Meeting at The Greenbrier in White Sulphur Springs, August 22-25, 1973, will be acted upon finally by the House of Delegates at the 107th Annual Meeting at The Greenbrier, August 21-24, 1974.

The proposed amendent follows:

Amend Article VI, Section 1, by deleting in the sixth line after the word "Treasurer," the words, "ex officio."

(Adoption of this amendment would make the Treasurer of the Association a voting member of the Council.)

State Physicians Elected To ACP Offices At Annual Session

Edmund B. Flink, M.D., of Morgantown was one of eight physicians elected to the American College of Physicians Board of Regents at the ACP Annual Session this past spring in New York City.

Jack H. Baur, M.D., of Huntington was elected to serve as an ACP Governor while John E. Jones, M.D., of Morgantown was voted into office as a Governor-Elect.

Robert G. Petersdorf, M.D., Professor and Chairman of the Department of Medicine at the University of Washington, Seattle, Washington, was chosen President-Elect of the 26,500-member internal medicine specialty society.

Looking Back 10 Years . . .

Dr. J. P. McMullen of Wellsburg, left, Chairman of the Scholarship Committee for the State Medical Association in 1964, is shown with Carl E. Nichols of Glenville and Byron L. Van Pelt of Bethany, the 1964 recipients of four-year scholarships to the West Virginia University School of Medicine that year.

State Medical Association Lists Names of New Members

The following is a list by component societies of new members of the West Virginia State Medical Association elected since January 1, 1974:

Cabell

Anton, Charles J., Jr. — Huntington
Christian, Homer Lee — "
Hunter, G. G. — "
Oakes, Sally L. — "
Ottaviano, J. V. — "
Ratcliff, Bruce A. — "
Turner, William R. — "

Central W. Va.

Wiest, Jeanie A. — Buckhannon

Eastern Panhandle

Agnir, Orlando I. — Martinsburg
Bandolon, Pura K. — "
Boholst, Albert M. — Charles Town

Fayette

Mirza, Abdul Majid — Montgomery
Montgomery, Michael — Oak Hill

Greenbrier Valley

Alidina, Amir A. — Ronceverte
Coombes, W. N. — "
Plybon, Benjamin L. — "

Hancock

Isla, Roger — Weirton
Petrola, Frank L. — "

Harrison

Bryant, James L. — Clarksburg
Cornwell, Creel S., Jr. — "
Mendoza, Catalino B., Jr. — "
Pletcher, Robert O. — "
Rabanal, Aristotle — Salem

Kanawha

Basu, Dilip Kumar — Charleston
Farmer, Donald E. — "
Hansbarger, Echols A., Jr. — "
Hayes, Thomas M. — "
Holland, Reuben W., Jr. — "
Johnson, Benjamin A. — "
Lee, Bong Sook K. — "
Majestro, Tony C. — "
McCoy, Leslie F. — "
Sandhu, Ujjal S. — "
Tanguilig, Ernesto R. — "

Logan

Claravall, Leonardo — Holden
Dujovne, Hugo — Man
Dujovne, Saul — "
Mendoza, Clemente — "
Natera, Leonte — "
Razon, Benjamin M. — Holden
Pacis, Flora F. — Man

Marion

Crittenden, William C. — Fairmont
Kline, Deloris I. — "

Mason

Montero, Maruanito R. — Lakin

McDowell

Arroyo, Zeferino — Welch
Canero, Martin P., Jr. — "
Kuppusami, Muthusami — "
Miranda, Romulo — "

Mercer

Hoback, Daniel P. — Bluefield, Va.
Krishnan, Radha — Bluefield
Salas, B. L., Jr. — Ventura, Cal.
Shah, M. W. — Princeton

Mingo

Deang, C. R. — Williamson
Wu, Lawrence — Renova, Pa.

Monongalia

Johnson, Jerome G. — Morgantown
Jones, John Evan — "
Kerr, Richard S. — "
Khoury, George H. — "
Ramanan, S. V. — "
Rhudy, Joe Wesley — "
Stemple, Larry Jack — "
Stevenson, Mabel M. — "
Withersty, David J. — Star City
Wolf, John H., Jr. — Morgantown

Ohio

Entress, Cheryl — Wheeling
Hill, David P. — "
Jacob, James A., Jr. — "
McConnell, D. Verne — "
McNeer, Michael D. — "
Szalontay, Zoltan — "
Widlan, Sheldon — "

Parkersburg Academy

Avington, M. D. — Parkersburg
Aya-Ay, J. M. — Grantsville
Strobl, W. W. — Parkersburg

Raleigh

Ames, David A. — Beckley
Andrada, Adolfo A. — "
Bembalkar, Shrinkant L. — "
Betinis, John I. — "
Hollifield, Guy F. — "
Jacobson, Arthur Ray — "
Mathews, James J. — "
Orphanos, George — "
Pia, Felipe T., Jr. — "
Serina, Eliseo B. — "
Subbaraya, L. H. — "

Summers

Haggstrom, G. A. — Hinton
Isterabadi, A. H. — "
Jimenez, E. L. — "

Tygart's Valley

Menon, K. P. S. — Elkins
Santa, N. — "
Thimmappa, B. G. — Philippi
Woodford, James William — "

Wyoming

Floresca, Jose — Beckley

Drs. Battaglino and Pulliam Honored

Dr. John J. Battaglino, Jr., of Wheeling, has been named Section Chairman Elect of the West Virginia Section of the American College of Obstetricians and Gynecologists and will be installed at the Annual Meeting of District IV of the College in Baltimore, October 13-16.

Dr. Robert P. Pulliam of Beckley is the Section Vice Chairman Elect for West Virginia and also will be installed at the same meeting.

Auxiliary Completes Program For 50th Annual Meeting

Mrs. Howard J. Liljestrand of Hawaii will be among honor guests when the Woman's Auxiliary to the West Virginia State Medical Association holds its 50th Annual Meeting at The Greenbrier in White Sulphur Springs August 21-24.

The meeting again will be held concurrently with the Annual Meeting of the State Medical Association. Mrs. Liljestrand was installed in Chicago in June as the new President of the Woman's Auxiliary to the American Medical Association.

Also addressing the Auxiliary will be Mrs. W. Nash Thompson of Stuart, Virginia, President of the Woman's Auxiliary to the Southern Medical Association.

More than 200 wives of physicians are expected to attend the Auxiliary's business sessions, over which Mrs. J. Dennis Kugel of Charleston, the State Auxiliary's President, will preside.

Pre-Convention Meetings

An invitation has been extended to all Auxiliary members to attend the first session of the State Medical Association's House of Delegates on Wednesday, August 21, at 2:30 P. M. Dr. Malcolm C. Todd of Long Beach, California, President of the American Medical Association, will be the principal speaker.

Mrs. Kugel then will preside at a 4 P. M. pre-convention Auxiliary Board meeting in the Fillmore-Van Buren Rooms.

Opening Convention Exercises

Members of the Auxiliary also have been invited to attend formal opening ceremonies of the State Medical Association's 107th Annual Meeting at 9 A. M. on Thursday, August 22, in Chesapeake Hall. Sen. Robert C. Byrd of West Virginia will deliver the second annual "Thomas L. Harris Address."

Following the opening exercises, the Auxiliary members will go to the Fillmore — Van Buren Rooms for the formal opening of their convention, with Mrs. Kugel in charge.

First General Session

The keynote address by Mrs. Liljestrand will highlight the initial session at 9:45 A. M. Dr. A. Thomas McCoy of Charleston, President of the State Medical Association, will be recognized for brief remarks.

Other opening-session items will include the introduction of the convention Co-Chairmen, Mrs. O. M. Harper of Clendenin and Mrs. A. G. Capinpin of Charleston; reports from officers and committee chairmen, recommendations from the pre-convention Board meeting, election of the 1975 Nominating Committee, and introduction of component Auxiliary Presidents by the Regional Directors.

Mrs. J. Dennis Kugel

Bridge, Past Presidents' Breakfast

A bridge tournament beginning at 2 P. M. will be held on Thursday in the Trellis Lobby. The Marion County Auxiliary will serve in a hostess role, with Mrs. Harry C. Fleming of Fairmont as Chairman.

At 8 A. M. on Friday, August 23, the Past Presidents' Breakfast will be held, with Mrs. Robert G. Janes of Fairmont, Immediate Past President of the State Auxiliary, presiding.

Second General Session

The Second General Session at 9:45 A. M. on Friday in the Fillmore — Van Buren Rooms again will have Mrs. Kugel presiding with a highlight to be the address by Mrs. Thompson.

Other activities will include the presentation of the AMA-ERF Awards to the Auxiliary by Associate Dean David Z. Morgan of the West Virginia University School of Medicine, and Mrs. Robert R. Weiler of Wheeling, State Chairman. Mrs. William J. Reardon of McLean, Virginia, Eastern Regional AMA-ERF Chairman, also will participate.

Mrs. Liljestrand will install Mrs. William T. Lawson of Fairmont as the new Auxiliary President. Other officers will be elected after a report from the Nominating Committee, and Mrs. Kugel will receive the Past President's Pin from Mrs. Janes.

Friday Social Functions

The Harrison County Auxiliary, with Mrs. Charles S. Harrison of Clarksburg serving as Chairman, will

be hostess for golf on Friday afternoon, and the Kanawha County Auxiliary, with Mrs. Thomas J. Janicki of Charleston as Chairman, will be hostess for tennis. The Raleigh County Auxiliary will be in the hostess role for the 50th Anniversary Ball at 10 P. M. in the new Colonial Hall. Mrs. R. James Yates of Beckley will be Chairman for the event. All physicians, their wives and others registered for the State Medical Association convention are invited.

Post-Convention Board Meeting

Mrs. Lawson will preside at the post-convention conference and Board Meeting at 10 A. M. on Saturday, August 24, in the Fillmore-Van Buren Rooms.

Saturday Afternoon Agenda

Auxiliary members are invited to attend the second and final session of the State Medical Association's House of Delegates on Saturday at 2:30 P. M., at which time Doctor McCoy will deliver his Presidential Address. Dr. William E. Gilmore of Parkersburg will be installed as the Association's President, and other Association officers will be elected.

Other Convention Matters

Those Auxiliary members who plan to participate in bridge, golf and tennis are urged to sign up in advance at the registration desk.

Meeting of Chest Physicians In New Orleans, Nov. 3-7

"Meeting Tomorrow's Clinical Needs Today" is the theme of the 40th Annual Scientific Assembly of the American College of Chest Physicians to be held at the Marriott Hotel in New Orleans, Louisiana, November 3-7, 1974.

The meeting will feature nationally known physicians discussing such topics as "Long-Term Membrane Oxygenation," "Newer Methods of Cardiopulmonary Support" and "Lung Cancer—Current Overview." Three thousand physicians and allied health professionals are expected to attend the Assembly, which will feature five days of workshops, symposia, fireside conferences and the presentation of original investigations. Also highlighting the meeting are medical motion pictures, luncheon panels, evening seminars and tutorial sessions.

Opening day, will offer physicians an opportunity to participate in one of several simultaneous scientific sessions in academic centers in New Orleans. In addition, a national seminar for nurses and allied health professionals will be held Monday, discussing care and management of patients with critical care cardiopulmonary problems.

Change of Address

Members of the West Virginia State Medical Association are requested to notify the headquarters offices promptly concerning any change in address. Notices should be mailed to Box 1031, Charleston, West Virginia 25324.

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled in the coming months.

1974

Aug. 2-4—International Doctors in AA, O'Hare Airport (Inn).

Aug. 12-15—Am. Hosp. Assn., Chicago.

Aug. 21-24—107th Annual Meeting, W. Va. State Medical Assn., White Sulphur Springs.

Sept. 4-7—Am. Assn. Ob.-Gyn., Hot Springs, Va.

Sept. 5-7—Tri-State Otolaryngology Meeting, Sea Island, Ga.

Sept. 9-11—AMA Congress Occupat. Health, Chicago.

Sept. 16-19—Ky. Med. Assn., Louisville.

Sept. 18-20—Int. Symp. Epidemiology of Hypertension, Chicago.

Sept. 18-21—Am. Thyroid Assn., St. Louis.

Sept. 20-21—Symp. on Neonatology, El Paso.

Sept. 24-26—Kentucky Medical, Louisville.

Sept. 24-27—Am. Roentgen Ray Soc., San Francisco

Sept. 27-28—Am. Heart Assn., W. Va. Affiliate, Annual Meeting & Scientific, Wheeling.

Sept. 27-Oct. 2—Internat. Coll. of Surgeons, Portland.

Oct. 5-8—Am. Assn. of Ophthalmology, Dallas.

Oct. 6-10—Am. Acad. Oph. & Otol., Dallas.

Oct. 14-17—AAFP, L. A.

Oct. 16-18—Am. Cancer Society, New York.

Oct. 17-19—Am. Assn. for Surgery of Trauma, Hot Springs, Va.

Oct. 19-24—Am. Acad. Pediatrics, San Fran.

Oct. 20-22—Am. Coll. Preventive Med., N. Orleans.

Oct. 21-25—ACS Clinical, Miami Beach.

Oct. 21-26—Am. Coll. Gastroent., Bal Harbour, Fla.

Oct. 23-26—Pa. Medical Soc. Scientific, Harrisburg.

Oct. 24-27—Am. Acad. Child Psychiatry, San Fran.

Oct. 29-30—Am. Assn. Study of Liver Diseases, Chicago.

Nov. 1-3—Med. Soc. of D. C., White Sul. Springs.

Nov. 3-6—Med. Soc. Va., Williamsburg.

Nov. 6-9—Am. Soc. Cytology, N. Y. City.

Nov. 14-16—W. Va. Chap., ACS, Morgantown.

Nov. 17-20—Southern Med Assn., Atlanta.

Nov. 30-Dec. 4—AMA Clinical, Portland.

Dec. 7-10—Am. Soc. Hematology, San. Fran.

Dec. 7-12—Am. Acad. Dermatology, Chicago.

Dec. 9-12—Southern Surgical Assn., Atlanta.

1975

Jan. 24-26—8th Annual Mid-Winter Clinical Conf., Charleston.

Jan. 31-Feb. 2—Southern Radiological Conf., Point Clear, Ala.

Feb. 10-13—Am. College Cardiology, Houston.

CONVENTION PROGRAM

107th ANNUAL MEETING

of the

West Virginia State Medical Association

THE GREENBRIER, WHITE SULPHUR SPRINGS

August 21-24, 1974

WEDNESDAY MORNING

August 21

(Eastern Daylight Time)

9:00-5:00—Registration, Main Floor Lobby.

10:00—Pre-Convention Meeting of the Council. Worthy W. McKinney, M. D., Presiding (Lee Room, Virginia Wing).

WEDNESDAY AFTERNOON

2:30—First Session of the House of Delegates. A. Thomas McCoy, M.D., Presiding (Chesapeake Hall).

Invocation—Carl B. Hall, M.D.

Address: Malcolm C. Todd, M. D., President, American Medical Association.

Presentation of AMA-ERF Check to the West Virginia University School of Medicine.

Business Meeting.

WEDNESDAY EVENING

6:30-7:30—President's Reception for Honor Guests (Chesapeake Hall Terrace).

THURSDAY MORNING

August 22

8:30-5:00—Registration, Main Floor Lobby.

Opening Exercises

(Chesapeake Hall)

9:00—Call to Order—A. Thomas McCoy, M.D., President, West Virginia State Medical Association.

Invocation—Joseph T. Skaggs, M.D.

Address of Welcome—A. Thomas McCoy, M. D.

Introduction of J. Hugh Wiley, M.D., 1974 Program Committee Chairman.

"The Thomas L. Harris Address"

Hon. Robert C. Byrd, Majority Whip of the United States Senate.

First General Session

"Symposium on Newer Concepts in Infectious Diseases"

Moderator: Philip M. Sprinkle, M.D.

9:45—Albert S. Klainer, M.D., and Robert W. Veltri, Ph.D., Members of the Faculty, West Virginia University School of Medicine, Morgantown. Subject: "Current Immunization Mechanisms."

10:15—Louis Weinstein, M.D., Chief, Division of Infectious Diseases and Professor of Medicine, Tufts University School of Medicine, Boston. Subject: "Effects of Antibiotics on Changing Spectrum of Infection."

10:45—Coffee Break.

11:00—Charles H. Kirkpatrick, M. D., National Institute of Allergy and Infectious Diseases, Bethesda, Maryland. Subject: "Immunotherapy of Chronic Infectious Diseases."

11:30—Virgil M. Howie, M.D., Pediatrician, Huntsville, Alabama. Subject: "Acute Otitis Media."

12:00—Panel Discussion and Question and Answer Period.

12:30—Recess for Lunch.

THURSDAY AFTERNOON

2:00—Resolutions Committee—Richard E. Flood, M.D., presiding (West Virginia Room).

THURSDAY EVENING

6:00—Cocktail Party. West Virginia University Alumni

Association. Clark K. Sleeth, M.D., in charge (West Virginia Room).

6:00—Cocktail Party. The University of Virginia Medical School Foundation.

E. L. Crumpacker, M.D., in charge.

6:30—Cocktail Party. West Virginia Chapter, Medical College of Virginia Alumni Association. Carl J. Roncaglione, M.D., in charge (Old White Club).

7:30—Dinner Honoring Past Presidents of the West Virginia State Medical Association and their wives. Worthy W. McKinney, M.D., presiding (Fillmore-Van Buren Rooms).

FRIDAY MORNING

August 23

Breakfast Meetings

8:00—West Virginia Academy of Ophthalmology and Otolaryngology (Washington Room, Virginia Wing).

8:00—Section on Internal Medicine. Harold Selinger, M.D., presiding (Lee Room, Virginia Wing).

Panel Discussion: Louis Weinstein, M. D., Boston; Charles H. Kirkpatrick, M.D., Bethesda; and Robert F. Schilling, M.D., Madison, Wisconsin.

8:00—Section on Neurology, Neurosurgery and Psychiatry (Pierce Room).

Guest Speaker: Albert J. Azzaro, Ph.D., Assistant Professor of Neurology and Pharmacology, West Virginia University School of Medicine, Morgantown. Subject: "Brain Catecholamines and Affective Brain Disorders."

8:00—Section on Orthopedic Surgery. Robert W. Lowe, M.D., presiding (Buchanan Room).

Guest Speaker: Allen H. Mackenzie, M.D., Cleveland, Ohio. Subject: "Efficacy Versus Safety of Potent Rheumatologic Drugs."

8:00—Sections on Urology and Surgery. Harold N. Kagan, M.D.; and Alvin L. Watne, M.D., presiding (Jackson Room).

Guest Speaker: James F. Glenn, M.D., Durham, North Carolina. Subject: "Stress Incontinence."

8:00—West Virginia Radiological Society. Joseph M. Aceto, M.D., presiding (Director's Room). Business Meeting.

8:30-5:00—Registration, Main Floor Lobby.

Second General Session

Moderator: Winfield C. John, M.D.

9:30—James F. Glenn, M.D., Professor and Chief of the Division of Urologic Surgery, Duke University Medical Center, Durham, North Carolina. Subject: "Surgical Causes of Hypertension."

10:15—Allen H. Mackenzie, M.D., Staff Member of the Division of Medicine, Department of Rheumatic Disease, Cleveland Clinic Foundation, Cleveland. Subject: "Diagnosis of Arthritis and Rheumatism in Children."

11:00—Coffee Break.

11:15—Robert F. Schilling, M.D., Washburn Professor of Medicine, University of Wisconsin Medical School, Madison. Subject: "The Logical Approach to Anemia."

12:00—Recess for Lunch.

12:15—Meeting of Cancer Committee. Alvin L. Watne, M.D., presiding (Main Dining Room).

FRIDAY AFTERNOON

2:00—West Virginia Chapter, American Academy of Pediatrics. Barbara Jones, M.D., presiding (Fillmore Room).

Guest Speaker: Virgil M. Howie, M.D., Huntsville, Alabama. Subject: "Recurrent Acute and Serous Otitis Media."

4:00—West Virginia Chapter, American Society of Internal Medicine. Leo H. T. Bernstein, M.D., presiding (Jackson Room).

4:00—West Virginia District Branch, American Psychiatric Association. Thomas S. Knapp, M.D., presiding (Director's Room).

5:00—Committee on Nominations. Harry S. Weeks, Jr., M.D., presiding (Lee Room, Virginia Wing).

FRIDAY EVENING

10:00—50th Anniversary Ball sponsored by the Woman's Auxiliary. Hostess: Raleigh County Auxiliary —Mrs. R. James Yates, Chairman (Colonial Hall).

SATURDAY MORNING

August 24

9:00-2:00—Registration, Main Floor Lobby.

Third General Session

"Department of Family Practice At the WVU School of Medicine"

Moderator: Ray M. Kessel, M.D.

9:30—Speaker: John W. Traubert, M.D., Chairman of the Department, Will Discuss the Development and Future Plans for the Department of

Family Practice at the WVU School of Medicine.

"What Are the Barriers to An Improved Medical Practice In the State of West Virginia?"

Moderator: J. Hugh Wiley, M.D.

The floor will be open for discussion of all questions physicians in the audience believe need to be answered in re such subjects as PSRO, malpractice insurance, etc.

SATURDAY AFTERNOON

2:30—Second and Final Session of the House of Delegates. A Thomas McCoy, M. D., presiding (Chesapeake Hall).

Invocation—Joe N. Jarrett, M.D.

Presidential Address: A. Thomas McCoy, M.D., President, West Virginia State Medical Association.

Presentation of New Officers of Woman's Auxiliary to the West Virginia State Medical Association.

Presentation of Honor Guests.

Business Meeting.

Election of Officers.

Installation of William E. Gilmore, M. D., of Parkersburg, as President of the West Virginia State Medical Association.

SATURDAY EVENING

6:30-7:30—Cocktail Party and Reception Honoring Officers of the West Virginia State Medical Association (Chesapeake Hall Terrace).

CONVENTION SPEAKERS

Albert S. Klainer, M. D.

Morgantown, W. Va.

Professor and Chairman, Division of Infectious Diseases, West Virginia University School of Medicine

Robert W. Veltri, Ph. D.

Morgantown, W. Va.

Associate Professor of Microbiology and Otolaryngology, West Virginia University School of Medicine

Charles H. Kirkpatrick, M. D.

Bethesda, Md.

National Institute of Allergy and Infectious Diseases, National Institutes of Health

Virgil M. Howie, M. D.

Huntsville, Ala.

Pediatrician

James F. Glenn, M. D.

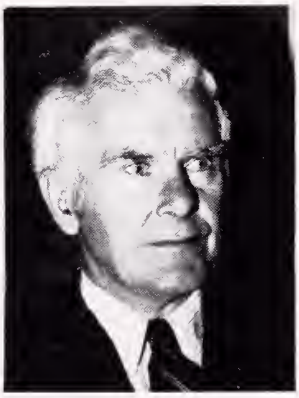
Durham, N. C.

Professor and Chief,
Division of Urologic Surgery
Duke University School
of Medicine

Allen H. Mackenzie, M. D.

Cleveland, Ohio

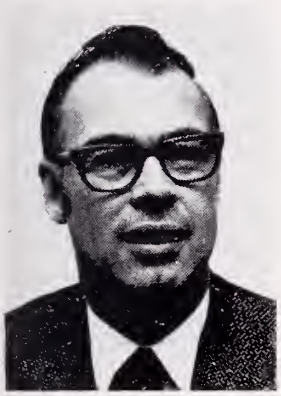
Staff Member, Division of
Medicine, Department of
Rheumatic Disease,
Cleveland Clinic Foundation



Robert F. Schilling, M. D.

Madison, Wis.

Washburn Professor of
Medicine, University of
Wisconsin Medical School



John W. Traubert, M. D.

Morgantown, W. Va.

Chairman, Department of
Family Practice, West Virginia
University School of Medicine

Albert J. Azzaro, Ph. D.

Morgantown, W. Va.

Assistant Professor, Neurology
and Pharmacology,
West Virginia University
School of Medicine

A WORD OF THANKS

The 1974 Program Committee, and the officers and members of the West Virginia State Medical Association, wish to acknowledge with sincere thanks grants received from the following Firms to help support the Scientific Program for this year's 107th Annual Meeting:

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Charleston, West Virginia

(The Firms listed above are those which had contributed to the Scientific Program as this issue of The Journal went to press. Additional contributors will be listed in the Official Program which will be distributed at The Greenbrier).

1974 PROGRAM COMMITTEE

J. Hugh Wiley
Morgantown
Chairman

Ray M. Kessel
Logan

William E. Gilmore
Parkersburg

Philip M. Sprinkle
Morgantown

John T. Chambers
Charleston

(A picture of another member of the Committee, Dr. Winfield C. John of Huntington, was not available at press time.)

DELEGATES AND ALTERNATES

BOONE (2)—Delegates, Harold H. Howell, Madison; and W. V. Wilkerson, Whitesville. Alternate, A. E. Glover, Madison.

BROOKE (2)—Delegates, James E. Wise, Follansbee; and W. T. Booher, Wellsburg. Alternates, Ralph McGraw, Follansbee; and W. T. Booher, Jr., Wellsburg.

CABELL (10)—Delegates, Winfield C. John, Joseph Edwin Ricketts, Albert C. Esposito, James P. Carey, Robert W. Lowe, Roy A. Edwards, Jr., Harold N. Kagan, John J. Brandabur, Charles E. Turner and Jack Leckie, Huntington. Alternates, William J. Echols, G. A. Ratcliff, Charles R. Hamlin and Edwin J. Humphrey, III, Huntington; W. W. Mills and H. S. Mullens, Kenova; and Charles E. McKay, Jr., and C. A. Hoffman, Huntington.

CENTRAL WEST VIRGINIA (3)—Delegates, Joseph B. Reed, Buckhannon; Louis W. Groves, Jr., Richwood; and I. Frank Hartman, II, Buckhannon. Alternates, R. L. Chamberlain, Buckhannon; C. R. Davisson, Weston; and Yong Don Joo, Summersville.

EASTERN PANHANDLE (4)—Delegates, Jean P. Lucas and Leo H. T. Bernstein, Martinsburg; Hiram Sizemore, Jr., Shepherdstown; and L. Walter Fix, Martinsburg. Alternates, William R. McCune, Norman Samuels, William L. Rodgers, William H. Wanger and Frank J. Gavlas, Martinsburg.

FAYETTE (3)—Delegates, Carl R. Adkins, Fayetteville; and Joe N. Jarrett and Ivan H. Bush, Jr., Oak Hill. Alternate, W. P. Bittinger, Oak Hill.

GREENBRIER VALLEY (3)—Delegates, Harold P. Dinsmore, Ronceverte; Lee B. Todd, Quinwood; and Harvey A. Martin, White Sulphur Springs. Alternates, Eugene J. Morhous and Arnold J. Brody, White Sulphur Springs; and Robert G. Shirey, Lewisburg.

HANCOCK (3)—Delegates, Richard E. Flood, Ray S. Greco and David H. Williams, Weirton. Alternates, Dominic A. Brancazio, Thomas J. Beynan and J. L. Thompson, Weirton.

HARRISON (5)—Delegates, Robert D. Hess, Bridgeport; M. V. Kalaycioglu, Shinnston; Julian D. Gasataya, Lumberport; and Cordell A. de la Pena, Clarksburg. Alternates, Charles S. Harrison, Paul E. Gordon, J. D. H. Wilson and Joseph Gilman, Clarksburg.

KANAWHA (17)—Delegates, Carrel M. Caudill, Charleston; Donald E. Cunningham, St. Albans; W. Alva Deardorff, Robert L. Ghiz, Carl B. Hall, John M. Hartman, J. L. Mangus, John B. Markey and Joseph T. Skaggs, Charleston; R. S. Birckhead, Gauley Bridge; William H. Carter and George V. Hamrick, Charleston; George W. Hogshead, Nitro; and Robert L. Leadbetter, Seigle W. Parks, G. A. Shawkey and P. A. Tuckwiller, Charleston. Alternates, Arthur A. Abplanalp, Jacques Charbonniez and John A. B. Holt, Charleston; James T. Hughes, Ripley; Thomas J. Janicki, Thomas S. Knapp, J. Dennis Kugel, Ralph H. Nestmann and Robert E. O'Connor, Charleston; Richard C. Rashid, South Charleston; and Carl J. Roncaglione, Merle S. Scherr, Jose M. Serrato and John F. I. Zeedick, Charleston.

LOGAN (4)—Delegates, Jorge J. San Pedro, Man; Ray M. Kessel, Logan; Thomas P. Long, Man; and A. A. Pelaez, Logan.

MARION (4)—Delegates, William T. Lawson and E. G. Cadogan, Fairmont. Alternate, Joseph T. Mallamo, Fairmont.

MARSHALL (3)—Delegates, Kenneth J. Allen, Glen Dale; David L. Ealy, Moundsville; and E. Y. Baysal, Glen Dale. Alternate, William Paul Bradford, Moundsville.

MASON (2)—Delegates, Antonio G. Sola and Aarom Boonsue, Pt. Pleasant. Alternates, John M. Grubb and Rogelio A. Averion, Pt. Pleasant.

McDOWELL (3)—Delegates, Arthur Allen Carr, Freeman L. Johnston and Charles F. McCord, Welch. Alternates, Mario Soto Cardona and Stephen Mamick, Welch; and John H. Murry, Gary.

MERCER (5)—Delegates, Frank J. Holroyd and L. J. Pace, Princeton; Sam Milchin, Bluefield, Virginia; and Upshur Higginbotham and John J. Mahood, Bluefield. Alternates, David F. Bell, Jr., R. O. Rogers, Jr., J. Elliott Blaydes, Jr., and Henry F. Warden, Jr., Bluefield; and Hawey A. Wells, Jr., Princeton.

MINGO (2)—Delegates, Charles H. Bruce and Paul E. Walker, Williamson. Alternates, Arthur E. Levy and Robert J. Tchou, Williamson.

MONONGALIA (6)—Delegates, Barbara Jones, Isaiah A. Wiles, Charles E. Andrews, George A. Curry, Robert L. Smith and H. Summers Harrison, Morgantown. Alternates, David Z. Morgan, Margaret I. Stemple, John L. Fullmer, Lawrance S. Miller and Philip M. Sprinkle, Morgantown.

OHIO (8)—Delegates, J. N. Aceto, W. E. McNamara, Robert J. Reed, III, M. D. Reiter, Thomas L. Thomas, Stephen D. Ward, Harry S. Weeks, Jr., and Robert R. Weiler, Wheeling. Alternates, Camilla K. Bauer, W. E. Ackermann, Alfred D. Ghaphery, Fernando C. Giustini, John P. Griffith, Jr., Donald H. Hofreuter, John W. Kennard and Jess S. Renedo, Wheeling.

PARKERSBURG ACADEMY (7)—Delegates, F. Lloyd Blair, Athey R. Lutz, Lyle D. Vincent, Dwight P. Cruikshank, Richard W. Corbitt, W. W. Strobl and Lewis D. Telle, Parkersburg. Alternates, Susan S. Gustke, Robert F. Gustke, Jose M. Talavera, S. William Goff and R. J. Bailey, Parkersburg.

POTOMAC VALLEY (3)—Delegates, Esteban Friera, Romney; Rano S. Bofill, Ft. Ashby; and M. F. Townsend, Petersburg. Alternates, Robert W. Bess, Jr., Piedmont; Dewey F. Bensenhaver, Petersburg; and Harry F. Coffman, Keyser.

PRESTON (2)—Delegates, Donald P. Brown, King-

wood; and Jerome C. Arnett, Rowlesburg. Alternates, Del Roy R. Davis, Kingwood; and William H. Harriman, Jr., Terra Alta.

RALEIGH (6)—Delegates, Charles W. Nelson, Jr., Richard G. Starr, C. Richard Daniel, James A. Gardner, James A. Barnes and Nicholas D. Zambos, Beckley. Alternates, Cordell R. Honrado, Mt. Hope; and Roy James Yates, John W. Whitlock, Everett B. Wray, Walter Klingensmith and F. Vivan Lilly, Beckley.

SUMMERS (2)—Delegates, A. W. Holmes and Buford W. McNeer, Hinton. Alternates, Davis William Ritter and Jack D. Woodrum, Hinton.

TYGART'S VALLEY (4)—Delegates, Robert R. Rector, Elkins; A. Kyle Bush and T. H. Chang, Philippi; and P. C. Tampoya, Grafton. Alternates, J. R. Woodford, Philippi; Wallace B. Murphy, Grafton; Guy H. Michael, Jr., Parsons; and L. H. Nefflen, Elkins.

WETZEL (2)—Delegates, Lemoyne Coffield, New Martinsville; and Allen M. Dyer, Jr., Pine Grove. Alternates, R. F. Miller, Paden City; and Kent M. Hornbrook, New Martinsville.

WYOMING (2)—Delegates, Ross E. Newman and George F. Fordham, Mullens.

Reception Committee

J. L. Mangus, Chairman

C. A. Hoffman
Frank J. Holroyd
Richard E. Flood
George R. Callender, Jr.
Harry S. Weeks, Jr.

J. Hugh Wiley
A. Thomas McCoy
Hawey A. Wells, Jr.
Philip M. Sprinkle
Winfield C. John

Albert S. Klainer
Joseph T. Skaggs
Herbert H. Pomerance
Thomas O. Dotson
M. D. Reiter

Barbara Jones
W. Gene Klingberg
George A. Shawkey
James W. Lane
Ralph J. Holloway
Harold N. Kagan

James T. Smith
Robert W. Lowe
Robert L. Ghiz
Arthur A. Abplanalp
Thomas F. Scott

Carl J. Roncaglione
William E. Gilmore
John M. Hartman
James T. Hughes
William H. Carter

J. L. Mangus
John J. Mahood
L. J. Pace
Jack Leckie
Albert C. Esposito

Richard W. Corbitt
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J. C. Huffman
George F. Evans
John T. Chambers

Official Program

WOMAN'S AUXILIARY

to the

West Virginia State Medical Association

50th Annual Meeting

THE GREENBRIER

White Sulphur Springs

August 21-24, 1974

WEDNESDAY AFTERNOON

August 21

2:30—First Session of the House of Delegates, State Medical Association (Chesapeake Hall).

Address by Dr. Malcolm C. Todd, President, American Medical Association.

4:00—Pre-Convention Board Meeting, Mrs. J. Dennis Kugel, President, presiding (Fillmore-Van Buren Rooms).

WEDNESDAY EVENING

6:30-7:30—President's Reception for Honor Guests (Chesapeake Hall Terrace).

THURSDAY MORNING

August 22

9:00—Formal Opening of the 107th Annual Meeting of the West Virginia State Medical Association (Chesapeake Hall).

"The Thomas L. Harris Address"

Hon. Robert C. Byrd, United States Senator from West Virginia.

(Auxiliary Members are Invited to Attend).

9:45—Formal Opening of the Convention, Mrs. J. Dennis Kugel, President, presiding (Fillmore-Van Buren Rooms).

Invocation—Mrs. Claude R. Davisson.

Pledge of Loyalty—Mrs. Claude R. Davisson.

Memorial Service—Mrs. Claude R. Davisson.

Introduction of Honor Guests.

Presentation of A. Thomas McCoy, M. D., President, West Virginia State Medical Association.

Introduction of Convention Co-Chairmen—Mrs. O. M. Harper and Mrs. A. G. Capinpin.

Roll Call of Delegates—Mrs. Claude S. Lawson.

Convention Rules of Order—Mrs. Robert G. Janes.

Treasurer's Report—Mrs. J. L. Mangus.

Credentials and Registration—Camilla K. Bauer, M.D.

Keynote Address—Mrs. Howard Liljestrand, President, Woman's Auxiliary to the American Medical Association.

Recommendations from Pre-Convention Board Meeting—Mrs. J. Dennis Kugel.

New Business and Announcements.

Report of the Nominating Committee, First Reading—Mrs. Robert G. Janes.

Election of 1975 Nominating Committee.

Reports of Officers and Standing Committee Chairmen (These reports will not be read, but are published in the Annual Reports Book).

Presentation of Component Auxiliary Presidents by the Regional Directors:

Eastern Region—Mrs. E. G. Friera.
Northern Region—Mrs. John D. H. Wilson.
Western Region—Mrs. D. Sheffer Clark.
Southern Region—Mrs. John Bryan.

Recess.

THURSDAY AFTERNOON

2:00—Bridge (Trellis Lobby), Hostess, Marion County, Mrs. Harry C. Fleming, Chairman.

FRIDAY MORNING

August 23

8:00—Past President's Breakfast, Mrs. Robert G. Janes, Immediate Past President, presiding (Virginia Room).

9:45—Second General Session—Mrs. J. Dennis Kugel, President, presiding.

Introduction of Honor Guests.

Roll Call of Delegates—Mrs. Claude S. Lawson.

Report of Reading Committee—Mrs. Gary G. Gilbert.

Reports of Convention Committees:

Finance—Mrs. Charles E. Andrews.
Credentials and Registration—Mrs. O. M. Harper.

Press and Publicity—Mrs. John E. McKenzie.

Presentation of AMA-ERF Awards.

Associate Dean David Z. Morgan, West Virginia University School of Medicine; Mrs. Robert R. Weiler, State Chairman; and Mrs. William J. Reardon, Eastern Regional AMA-ERF Chairman.

Address—Mrs. W. Nash Thompson, President, Woman's Auxiliary to the Southern Medical Association.

Unfinished Business.

Report of 1974 Nominating Committee, Second Reading—Mrs. Robert G. Janes.

Election of Officers.

Installation of Officers—Mrs. Howard J. Liljestrand, President, Woman's Auxiliary to the American Medical Association.

Presentation of President's Pin and Gavel—Mrs. J. Dennis Kugel.

Presentation of Past President's Pin—Mrs. Robert G. Janes.

Inaugural Address—Mrs. William T. Lawson.

Announcements

Adjournment.

FRIDAY AFTERNOON

2:00—Golf Tournament—Hostess, Harrison County, Mrs. Charles S. Harrison, Chairman.

Tennis Tournament—Hostess, Kanawha County, Mrs. Thomas J. Janicki, Chairman.

FRIDAY EVENING

10:00—50th Anniversary Ball—Hostess, Raleigh County, Mrs. R. James Yates, Chairman (Colonial Hall).

SATURDAY MORNING

August 24

10:00—Post-Convention Conference and Board Meeting —Mrs. William T. Lawson, President, presiding (Fillmore-Van Buren Rooms).

SATURDAY AFTERNOON

2:30—Second and Final Session of the House of Delegates of the State Medical Association (Chesapeake Hall).

Presidential Address—A. Thomas McCoy, M.D.

Installation of William E. Gilmore, M. D., as 1974-75 President of the West Virginia State Medical Association.

(Auxiliary Members are Invited to Attend).

SATURDAY EVENING

6:30-7:30—Cocktail Party and Reception Honoring the Officers of the West Virginia State Medical Association (Chesapeake Hall Terrace).

SCIENTIFIC EXHIBITS

AMERICAN CANCER SOCIETY
West Virginia Division, Inc.

"CONTROL OF CANCER OF THE UTERINE CORPUS." This exhibit points out the unchanging mortality rate from cancer of the uterine corpus, and the need for early diagnosis as the key to better control. It emphasizes the importance of a histologic examination of the endometrium in order to detect the precursors of this disease, and presents a flow chart for management of the high risk patient.

Patricia F. Haye, Program Director.

BLUE CROSS HOSPITAL SERVICE, INC. AND BLUE SHIELD OF SOUTHERN W. VA., INC.

This exhibit will explain the new automated utilization review program the plans have instituted for hospitalized private-pay subscribers.

C. Judson Pearson, President, and L. G. Bowling, Director of Research.

SOUTHERN MEDICAL ASSOCIATION

"DIAL ACCESS CANCER INFORMATION CENTER." The Dial Access System makes available toll-free telephone calls for physicians and other health practitioners to obtain the most recent diagnostic and therapeutic information on specific neoplastic disease problems. This type of information may direct patients on a course toward control of their cancer. The calls go to tape cartridge players carrying some 200 various narrations authored by members of the SMA who have expertise in the study and management of various types of cancer, and the M. D. Anderson Hospital and Tumor Institute (MDA) staff in Houston.

Roy B. Evans, Jr., Assistant Executive Director.

STATE COMPREHENSIVE HEALTH PLANNING AGENCY

"COMPREHENSIVE HEALTH PLANNING." This exhibit will offer materials and information about the development of CHP in the United States, West Virginia and in each of the 11 regions of the State. Staff members and others knowledgeable about the subject will be at the exhibit at all times to answer questions and receive suggestions. Physicians will have the opportunity to be informed about the new responsibilities assigned to CHP agencies by federal legislation.

Harry A. Stansbury, Jr., Ph. D., Director; Alfred Broadhead, Planner IV, and Gary Richards, Planner III.

THE MYERS CLINIC—BROADDUS HOSPITAL

"PATHOLOGY OF THE HEART." This exhibit presents a concise study of cardiac pathology, utilizing statistics, gross specimen slides and photomicrographs. Cardiac conditions are shown with special emphasis being placed on arteriosclerotic heart disease.

F. R. Franyutti, M. D.; and J. Richard Crawford.

U. S. SOCIAL SECURITY ADMINISTRATION

"YOUR SOCIAL SECURITY." Before you or your family can get any Social Security checks, you must apply for them. Get in touch with any Social Security office if: You're unable to work because of an illness or injury that is expected to last a year or longer. You're 62 or older and plan to retire. You're within two or three months of 65 even if you don't plan to retire. Someone in your family dies. It's important for you to call, visit or write any Social Security office before you reach 65, not only about retirement checks, but also about Medicare, which is available whether or not you retire.

Christine W. Elliott, Manager; Kenneth White, Operations Supervisor, and James H. Swaim, Field Representative.

WEST VIRGINIA DEPARTMENT OF WELFARE
Division of Medical Care (Medicaid)

"MEDICAID — MEDICALLY NEEDY." The West Virginia Medicaid Program administered by the Department of Welfare is expanding eligibility to include low income medically indigent individuals. It is anticipated that an additional 100,000 West Virginians will become eligible for Medicaid coverage. This year's exhibit will be devoted to an illustration of the Department's eligibility determination procedures reflecting income and asset levels with an explanation of "spend-down" and other related information. Exhibit emphasis will be with respect to eligibility requirements as Medicaid Program coverage will remain unchanged for the newly eligible medically indigent group. A general understanding of the eligibility principles will help physicians in their delivery of medical care to Medicaid patients.

WEST VIRGINIA MEDICAL INSTITUTE, INC.

This exhibit will depict the current and developing activities of the Institute.

Charles R. Lewis, Executive Director.

WEST VIRGINIA REGIONAL MEDICAL PROGRAM

"THE PAS SYSTEM: YOUR TOOL FOR PATIENT CARE EVALUATION." A table top display telling what PAS is and how it can help.

Warren H. Moss, Project Specialist.

WEST VIRGINIA LUNG ASSOCIATION

"Ilo U-C International Classification of Pneumoconioses." These slides which will be shown are from the International Tuberculosis Conference held in Switzerland in 1971.

Melvin H. Lively, Executive Director.

WEST VIRGINIA STATE DEPARTMENT OF HEALTH

"IDENTIFICATION, DIAGNOSIS AND MANAGEMENT OF GONOCOCCAL INFECTIONS." Gonorrhea is the number one communicable disease problem today. This exhibit will up-date the practicing physician on the currently accepted medical philosophy for managing gonorrhea patients. The 15 to 20-minute auto-tutor designed program permits the physician to progress at his own speed. Three auto-tutors will be available. Personnel will be present to assist with the machine operation if needed and to discuss the West Virginia venereal disease problem and the steps being taken to control these diseases.

Ronald G. Bryant, Director, Bureau of Venereal Disease Control; and Thomas Nuzum and Robert Pinkerton, VD Representatives.

WEST VIRGINIA AFFILIATE, AMERICAN HEART ASSOCIATION

"HYPERTENSION." The exhibit will consist of continuous slides and tapes on the "Modern Pharmacological Management of Systemic Hypertension," a panel exhibit, and literature on "Recommended Anti-Hypertension Regimens for Groups with Varyingly Severe Hypertension as Indicated by Diastolic Pressure (in M M Hg.)." Nurses will be present between 10 A. M. and 12 P. M. Thursday and Friday to take blood pressures of members and their families.

Charles E. Sikorski, Executive Director, and Mrs. Deloris Kidd, Field Director, South Central, West Virginia Affiliate.

WEST VIRGINIA DEPARTMENT OF MENTAL HEALTH

"MENTAL HEALTH EDUCATION." The exhibit will feature two films, "The Social Seminar" and "One to Grow On," dealing with mental health in the classroom. For distribution will be the new Mental Health Code Revision (H. B. 910), the "Child's Bill of Rights," and "The Social Seminar" and "One to Grow On" brochures. Display items will include "A Guide to Drug Abuse Education" and information materials, and a step-by-step procedure for Mental Health Code revision.

Blaine P. Dowler, Coordinator, Division of Mental Health Education; Wayne Dawson, Educational Consultant, Division of Mental Health Education, and Robert D. Kerns, Ph. D., Director, Division of Professional Services.

WEST VIRGINIA ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY

"THE EYE AND EAR IN MULTIPHASIC HEALTH TESTING." A suitable battery of screening tests for eye and ear function will be demonstrated by appropriate technicians. Members of the West Virginia State Medical Association and their families and guests will be eligible for the testing program at no charge. The eye screening will include tests for visual acuity, ocular muscle balance fusion, stereopsis, dominance, color vision, visual fields, intra-ocular pressure, and refractive error. The ear testing will include otoscopic examination of the ear canal, compliance measurements of the tympanic membrane and middle ear system, and puretone audiometric thresholds.

Ralph W. Ryan, M. D., President-Elect, American Association of Ophthalmology; and Robert C. Cody, M. A., Assistant Professor and Director of Audiology, West Virginia University Medical Center.

WEST VIRGINIA UNIVERSITY COOPERATIVE EXTENSION SERVICE—4-H PROGRAMS

"4-H HEALTH PROGRAMS." The health programs developed by WVU throughout the State for use in the educational development of youth are depicted. The emphasis for this exhibit will be the 1974-75 eye health program, "Eyes Right."

C. Sue Cecil, Extension Specialist—4-H Programs, West Virginia University.

ANNUAL REPORTS

Cancer Committee

A meeting of the Cancer Committee was held at The Greenbrier on August 24, 1973, during the 106th Annual Meeting of the West Virginia State Medical Association.

In addition to your Chairman, other members of the Committee present included Drs. F. Lloyd Blair of Parkersburg, L. Walter Fix of Martinsburg, William E. Gilmore of Parkersburg, David B. Gray of Charleston, Hu C. Myers of Philippi, and John W. Trenton of Kingwood.

Guests at the meeting included Dr. N. H. Dyer, Director of the State Department of Health; Dr. William L. Cooke, Director of the Disease Control Division of the State Department of Health; Mr. Thorold S. Funk, Director of the Division of Vocational Rehabilitation; Dr. Leslie F. McCoy, Director of Medical Services for Vocational Rehabilitation; and Mr. Ora Winship, Jr., Staff Associate, West Virginia Hospital Association.

Doctor Dyer reported the following statistics on Cancer Control: 465 patients requested and received financial help; 147 patients were refused care because of advanced disease; the surgery fee schedule increased to $200 for major surgery and Cobalt increased to $10 with a slight increase in other radiology services.

During 1972, 4,292 new cases were added to the Central Cancer Registry.

Mr. Winship, reporting for the State Hospital Association, indicated Recaps of a Tumor Registry Survey in the State of West Virginia showed only three cancer registries operated as a separate unit from medical records. The cost statewide was over $120,000 for operation of registries. Doctor Gray pointed out the need to document the benefits to the patient of a cancer registry. He feels that the interest of physicians in local programs and registries is improving.

Mr. Funk reported Rehabilitation participation in care of the cancer patient is improving with more patients being cared for this year than last. Care of cancer patients is assuming greater importance in the Rehabilitation Program.

Doctor McCoy emphasized the use of the registry in determination of patients eligible for rehabilitation. The Cancer Committee wishes to commend Mr. Funk and his group for their interest in the care of the cancer patient.

Doctor Gilmore commented on the West Virginia Division of the American Cancer Society Professional Education Program. He said the Ostomy groups, Uterine Cancer Task Force as well as the Reach to Recovery program are increasing and very effective. He also commended the "Lost Chord Club."

Respectfully submitted,
Alvin L. Watne, M. D.
Chairman

June 5, 1974

Insurance Committee

Two developments have occurred that have a significant bearing on the operation of the State Medical Association's Group Insurance Program. The first is the development and publciation of the "Computer Audit." Our State Association sponsors eight separate Group Insurance Plans. A substantial percentage of the membership participates in all or most of the Plans offered. The "Computer Audit" furnishes each participating member a record of his insurance including the benefits payable, a brief description of his coverage, his premiums and due dates of each. It provides a coordinated picture of the Plans available . . . and exposes any gaps in a member's Program. An accompanying card enables him to request information on any plan in which he may be interested.

Since publication of the "Audit," our Resident Administrator has received a substantial response requesting information on various plans. The "Computer Audit" meets a need and is fulfilling a valuable service in the function of our Group Program.

Another important development is pending Universal Health Care legislation, essentially designed to cover all of the populace at least at a basic level. It appears now, after more than 10 years, that the various exponents of a Universal Health Care Plan have at last come to a consensus.

It is now the informed opinion of Congressional leaders that a bill will be reported either at the end of this year or the beginning of next. The full implementation will require some time. The exact final coverage has not yet been agreed upon by the involved parties. However, all the plans thus far advanced, including the general guidelines now agreed upon, leave substantial margins between the benefits payable under a Universal Health Care Plan and the type of coverage most of us need and want for the adequate protection of ourselves and our families. Accordingly, when the bill finally becomes law, the Association's present Family Major Hospital Plan will be carefully reviewed. A new plan will be designed for adequate protection . . . to meet the needs of our members and their families.

Malpractice and malpractice coverage continues to present problems. The upward trend of claims, both in frequency and amount, must be faced and dealt

with in the best interest of our members. On a comparative basis, our Program is as good as any and better than most. Nationally, companies have withdrawn from several states or threatened to do so. The Aetna continues to provide our membership a viable market and adequate coverage.

In another area, the Medical Liability Commission is now a reality. A meeting will be held within the next three weeks to name an Executive Director with headquarters in Chicago. This Commission is made up of supporting members of the following organizations:

American Academy of Dermatology
American Academy of Family Physicians
American Academy of Neurology
American Academy of Orthopaedic Surgeons
American Academy of Pediatrics
American Academy of Physical Medicine and Rehabilitation
American Association of Neurological Surgeons
American College of Obstetricians and Gynecologists
American College of Physicians
American College of Radiology
American College of Surgeons
American Dental Association
American Hospital Association
American Medical Association
American Psychiatric Association
American Society of Anesthesiologists
American Society of Internal Medicine
American Society of Plastic and Reconstructive Surgeons
American Urological Association
College of American Pathologists
Society of Thoracic Surgeons

The charge of this body is to attempt to alleviate and possibly cure the malpractice problem in this country which is adding so much directly and indirectly to the cost of medical care.

Respectfully submitted,
Charles A. Hoffman, M. D.
Chairman
Andrew J. Barger, M. D.
James A. Barnes, M. D.
Robert L. Chamberlain, M. D.
John T. Chambers, M. D.
R. U. Drinkard, M. D.
A. C. Esposito, M. D.
F. Perry Greene, Jr. M. D.
Upshur Higginbotham, M. D.
Kenneth G. MacDonald, M. D.
Buford W. McNeer, M. D.
J. C. Pickett, M. D.
Robert S. Robbins, M. D.
C. Vincent Townsend, M. D.

June 1, 1974

Venereal Disease Committee

A breakfast meeting of the Veneral Disease Committee was held at Oglebay Park in Wheeling on June 6, 1974. The following members of the Committee were present: Drs. N. H. Dyer, Chairman; and Thomas L. Thomas of Wheeling; M. A. Viggiano of New Martinsville; Lyle D. Vincent of Parkersburg; and I. A. Wiles of Morgantown.

Also in attendance were Mr. Ronald G. Bryant, Director of the Bureau of Venereal Disease Control of the State Health Department; and Mr. Joseph Carter, Deputy Regional Program Director of Disease Control.

Doctor N. H. Dyer, Chairman, opened the session by reflecting on the subject matter covered during the immediate past committee meeting, its recent accomplishments, and the change in the Committee's name from Syphilis Committee to Venereal Disease Committee to make it more representative of the responsibilities of this group.

Discussion involved considering the increased occurrence of venereal disease among the teen-age population in the State and the fact that many more of this age group are seeking medical evaluations for venereal disease, since the legislature's action which amended the law to permit diagnosing and treatment of minors without parental or guardian consent. The Committee was instrumental in the drafting of the amendment and actively supported its passage.

Several topics of new business were considered by the Committee:

(1) Change in the Minor Legislation of 1971. Doctor Vincent stated that some hospitals felt that the institutions were not free from libel for a minor treated by a physician in their facilities. One hospital concerned about the liability factor of treating without parental consent requested an interpretation by their hospital attorney who concluded that the hospital could be held libel. Doctor Dyer suggested an Attorney General's opinion in this matter. Doctor Thomas moved that an interpretation be requested from the Office of the Attorney General, and the motion was seconded by Doctor Vincent.

(2) Epidemiologic Treatment of Known Sexual Contacts to Infectious Venereal Disease and Its Importance to Control. During the past year in West Virginia, less than 80 per cent of the sexual contacts of gonorrhea cases interviewed were recorded as epidemiologically treated. Evidence indicates that the practice of preventively treating to abort the development of venereal disease in asymptomless document contacts to curtail the spread of infection often is not applied by the practicing physicians in the State. Studies reveal that 10 to 30 per cent of the persons exposed to early syphilis will become infected if not epidemiologically treated at the time of clinical examination as a contact to this disease and will in turn pass it on to others before realizing infectiousness.

It is reasonable to expect a much higher rate among those exposed to gonorrhea infections in the absence

of preventive treatment, since the wide use of the "pill" provides the female practically a 100 per cent chance of contracting gonorrhea if exposed to an infected sexual partner. By far the greatest reason expressed by physicians for hesitating to participate in this preventive technique is the concern about administering drugs when there is no manifested evidence of disease.

However, the treatment of persons exposed to infectious cases of syphilis and gonorrhea remains one of the most important ways to control these two diseases. In the view of many national and state medical authorities, an appropriate article on the subject, written by Dr. R. R. Wilcox, appears in the April 1973 issue of the British Journal of Venereal Disease entitled, "Epidemiological Treatment in Venereal Disease Other Than Syphilis." A quote from page 121 states, "Many of the opponents in principle of epidemiological treatment will nevertheless be tempted to give such treatment, and even post-exposure prophylactic treatment also, to individuals listed below, and some may even succumb to the temptation:

Themselves	Bishops and clergy
Their mistresses	High trade union officials
Their friends	Senior health administrators
Their accountant	Their medical colleagues
Their bank manager	(and relatives)
Private patients	Their wives and family

A number of West Virginia physicians have interpreted the minor venereal disease legislation of 1971 as providing the necessary safeguard to the medical person for the epidemiologic treatment of minors. It was the consensus of the Committee that all that is needed to epidemiologically treat adults then is the individual's consent. The Committee generally agreed that epidemiologic treatment was an important factor to the control of venereal disease; however, it was decided to delay action for further study and observation.

(3) Updating the Physician on Current Venereal Disease Chemotherapy. Members of the Committee expressed serious concern about the confusion among the medical professionals regarding the currently recommended Chemotherapy for the venereal disease, particularly gonorrhea and syphilis. It is feared that some treatment regimens of 20 years ago, now subtherapeutic, are still being used. Doctor Wiles' motion, which carried, urged that the State Medical Association take up this matter and use every avenue of communications to keep the physicians continuously informed of the current treatment regimen recommended for the venereal diseases.

The Committee adjourned with a tentative plan to convene again during the 107th Annual Meeting of the State Medical Association in August, 1974.

Respectfully submitted,
N. H. Dyer, M. D.
Chairman

June 13, 1974

107th ANNUAL MEETING

of the

West Virginia State Medical Association

The Greenbrier

AUGUST 21-24, 1974

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WVU Medical Center
–News–

• **Compiled from materiol furnished by Mrs. Mary Ellin Wylie, Director, Medical Center News and Informotion Services, Morgantown, W. Va.**

A former Professor of Pathology at the University of Iowa has been named Chairman of the Department of Pathology at West Virginia University School of Medicine.

Dr. Nathaniel Fulford Rodman, whose appointment was effective July 1, succeeds Dr. Milton A. Hales, who will remain on the faculty as Professor of Pathology.

Nathaniel F. Rodman, M.D.

A native of Norfolk, Virginia, Doctor Rodman attended Massachusetts Institute of Technology and was graduated from Princeton University. He received his M.D. degree from the University of Pennsylvania.

After serving his internship at Lankenau Hospital in Philadelphia, he completed one year as a fellow and resident in pathology at the University of North Carolina before a second tour of duty with the U. S. Navy.

Returning to North Carolina in 1955, he completed his residency and remained on the faculty of that university until he went to the University of Iowa in 1970.

Doctor Rodman is the author or co-author of more than 40 papers, many detailing his research in the area of thrombosis and hemorrhage with particular emphasis on the role of the blood platelet.

He is a member of 13 professional and learned societies including Alpha Chi Sigma, Sigma Xi, the Electron Microscopy Society of America, the American Society for Experimental Pathology, the International Academy of Pathology, and the International Society on Thrombosis and Haemostasis.

In 1968-70, he was the recipient of a National Heart and Lung Institute Research Career Development Award.

He also served as associate editor on two publications devoted to his field of research.

Scottish Surgeon Joins WVU Faculty

A Scottish surgeon, who was a visiting lecturer in the West Virginia University School of Medicine five years ago, has been appointed to the faculty of the Division of Otolaryngology.

Dr. Arnold George Maran, Professor of Surgery, comes to WVU from the University of Dundee and Dundee Royal Infirmary, where he has served as Senior Lecturer and Consultant in Otolaryngology since 1967. During this time, he also was Visiting Consultant Otolaryngologist at Maryfield Hospital in Dundee and at Arbroath Infirmary.

A graduate of Daniel Stewart's College in Edinburgh, he received his medical and specialty training at Edinburgh University and at the University of Iowa where he was a Fellow in head and neck surgery.

He has done wide research on the causes and treatment of vertigo resulting from middle ear involvement and has worked extensively with the problems of the deaf child. Since his training in the United States, his main area of interest has been head and neck surgery, particularly tumor surgery and plastic reconstruction. He is a founder member of the British Association of Head and Neck Oncologists, which was established in 1970.

His research and experience have been reported in a number of medical journals and in papers presented to national and international societies. He has also spent time at E. N. T. centers in Italy, Holland, Belgium, Germany and Scandinavia as well as in the larger cities of the United States.

He is a member of the Scottish Otolaryngological Society and several British and American associations of head and neck surgeons.

Pharmacologist Receives Award

A West Virginia University School of Medicine assistant professor has received a Faculty Development Award in Pharmacology from the Pharmaceutical Manufacturers Association Foundation. He is Dr. Michael G. Mawhinney, holder of a joint appointment in the Department of Pharmacology and the Department of Surgery's Division of Urology.

The award, which was effective July 1, is for a two-year period and will provide salary and fringe benefits support.

Offered for the first time last year by the Foundation, the awards go to selected junior faculty members committed to careers in pharmacology who give promise of outstanding accomplishments.

Doctor Mawhinney, a graduate of Grove City (Pa.) College, received M.S. and Ph.D. degrees in pharmacology from WVU. He joined the faculty in 1971.

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The Month in Washington

THE humdrum hearings on national health insurance (NHI) before the House Ways and Means Committee got something of a lift when the long-absent Chairman, Wilbur D. Mills, (D-Ark.), unexpectedly showed up one Friday in mid-June and announced that whatever bill his committee approves undoubtedly would not look like any single bill presently under consideration.

This pronouncement from the august Chairman immediately gave rise to the belief that closed door talks may be going on among committee members in an effort to hack out a compromise bill that could secure congressional enactment this year.

But the startling lack of interest evident in the House Ways and Means Committee hearings—only two or three members attending each hearing and Chairman Mills showing up for just the second time in months—and the indefinite postponement of Senate Finance Committee hearings would seem to say the Congress is not busting its britches to pass a NHI bill this year.

Mills said his own plan (Mills-Kennedy) "doesn't do everything I would like it to do." He said, however, he believes the method of reimbursing physicians under Mills-Kennedy is better than under Medicare. It would eliminate the apparent discrimination between the city physician and the rural physician, Mills believes.

He declared his primary concern is that the poor receive at least as good medical services as the rest of the people. Referring to the compromise with Kennedy, he said, "we were trying to lay before the public a program we thought had a chance to pass." He said he wanted to avoid a bill that "would provide nothing more than catastrophic," which would cover only five per cent of the need. The compromise is subject to further compromise, Mills said. Catastrophic is the roof, and "we need the floor and walls along with the roof."

Mills said his intent with the Mills-Kennedy compromise NHI bill was not to exceed the cost of the Administration's "Chip" plan and to come up with a different method of financing. He said the bill was introduced to present an alternative to the Administration plan for discussion and comment.

Here are selected sample bits of testimony from the many medical-health care oriented organizations who have trooped to Washington to have their say about NHI:

The American Public Health Association urged more consumer policy input than provided in any of the major NHI bills before the committee and more preventive services benefits. APHA President C. Arden Miller, M.D., said the major measures for the most part provide insufficient benefits and controls.

- **From the Washington Office of the American Medical Association.**

The American Association of Medical Clinics supported maintenance of the free enterprise system of health care, and said funding should be from mandated employer plans and general tax funds for the poor and medically indigent.

The Colorado Health and Environment Council witness discussed the Colorado Community - Cooperative-Decentralized plan which emphasizes preventive medicine and home health care. The importance of the physician's office as a basic health care facility was stressed.

The National Association of Social Workers favored the Kennedy-Griffiths, Health Security Act provisions.

The American Academy of Family Physicians told the House Ways and Means Committee any NHI bill must provide that family physicians receive the same fee as other specialists when providing the same service. Family physicians should not be treated as "second class members of the health care delivery team," said James Price, M.D., Academy President.

Wealthier people should pay a greater portion of the cost for catastrophic coverage as provided in the American Medical Association's Medicredit plan, he told the Committee.

"We are skeptical as to just how all-encompassing a program can be effectively administered by the federal government and would strongly urge that, insofar as possible, continued reliance be placed on the expertise which has been developed by the private insurance industry," he said.

Doctor Price opposed a provision of the Mills-Kennedy bill (Medicare for all) regarding payment for services by specialists, saying that the determination of which physicians should not be providing specific services should be left to their peers rather than the Social Security Administration.

Another witness, Donald Schiff, M.D. of the American Academy of Pediatrics, said "we must build upon the strengths of our present medical care system, taking special pains to retain the currently productive programs such as Crippled Children's, Maternal and Child Health, and Children and Youth."

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Diplomate, American Board of Ophthalmology

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Diplomate, American Board of Otolaryngology

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Maxillo-facial Surgery
Reconstructive Surgery
Head & Neck Surgery
Cryosurgery
Endoscopy
Oncology

OPHTHALMOLOGY and OTOLARYNGOLOGY

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John A. B. Holt, M.D.
Diplomate, American Board of Ophthalmology

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Catherine Kenney, CRNA
Inez Maggio, CRNA
Muriel Dodds, CRNA

Obituaries

R. E. BAER, M. D.

Dr. Robert E. Baer, a family physician and surgeon of South Charleston, died on June 23 at his home. He was 71.

Doctor Baer was a graduate of West Virginia University and received his M. D. degree in 1932 from Rush Medical College in Chicago. He practiced in White Sulphur Springs before moving to South Charleston in 1940 and was a past President of the Greenbrier Valley Medical Society.

Doctor Baer was a member of the Kanawha Medical Society and the West Virginia State Medical Association.

He is survived by the widow, a son, Robert E. Baer, Jr., of Martinsburg; two daughters, Mrs. Barbara Ann Musgrave of Centerville, Ohio and Mrs. Carolyn Mae Haught of Cedar Grove, New Jersey; two brothers, Herbert K. Baer of Bridgeport and Frank Baer of Santa Rosa, California, and a sister, Mrs. Virginia McAnulty of Dunedin, Florida.

Working hours required for average prescription purchase: In average hourly wages, it required one hour and eight minutes in 1972 to earn the price of the average prescription. Ten years ago, when the average hourly wage was much lower, it took one hour and 22 minutes.

AMA To Sponsor Conference On Occupational Health

The 34th Annual Congress on Occupational Health of the American Medical Association will be held Sept. 9-10 in Chicago (Marriott Motor Hotel).

Co-sponsor will be the National Institute for Occupational Safety and Health of the Center for Disease Control, (NIOSH-CDC) U. S. Department of Health, Education and Welfare.

The Congress program will emphasize discussion workshops, following formal lectures. All proceedings will be transcribed and edited by the AMA for the use of NIOSH-CDC in development of a professional manual for part-time occupational health physicians who work in small plants, said Henry F. Howe, M.D., Associate Director of the AMA's Department of Environmental, Public and Occupational Health. Doctor Howe is program director for the Congress.

The workshop sessions will discuss such subjects as occupational pulmonary diseases; cardiovascular disease in occupational medicine; cardiovascular demonstrations on work evaluation and stress testing; medical monitoring for occupational disease; case history presentations of diagnosis in chemical exposures; noise, hearing and audiometry; a dramatization and discussion of real problems in small industry, and demonstration of industrial hygiene environmental measurement techniques.

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J. W. Woodford, M. D.

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You know: The guy who wouldn't hurt a fly, turn down a friendly drink—or take a cab home instead of driving. A nice guy who'd now and then smoke in bed, maybe swim out a little too far, sometimes hurry a little down the stairs.

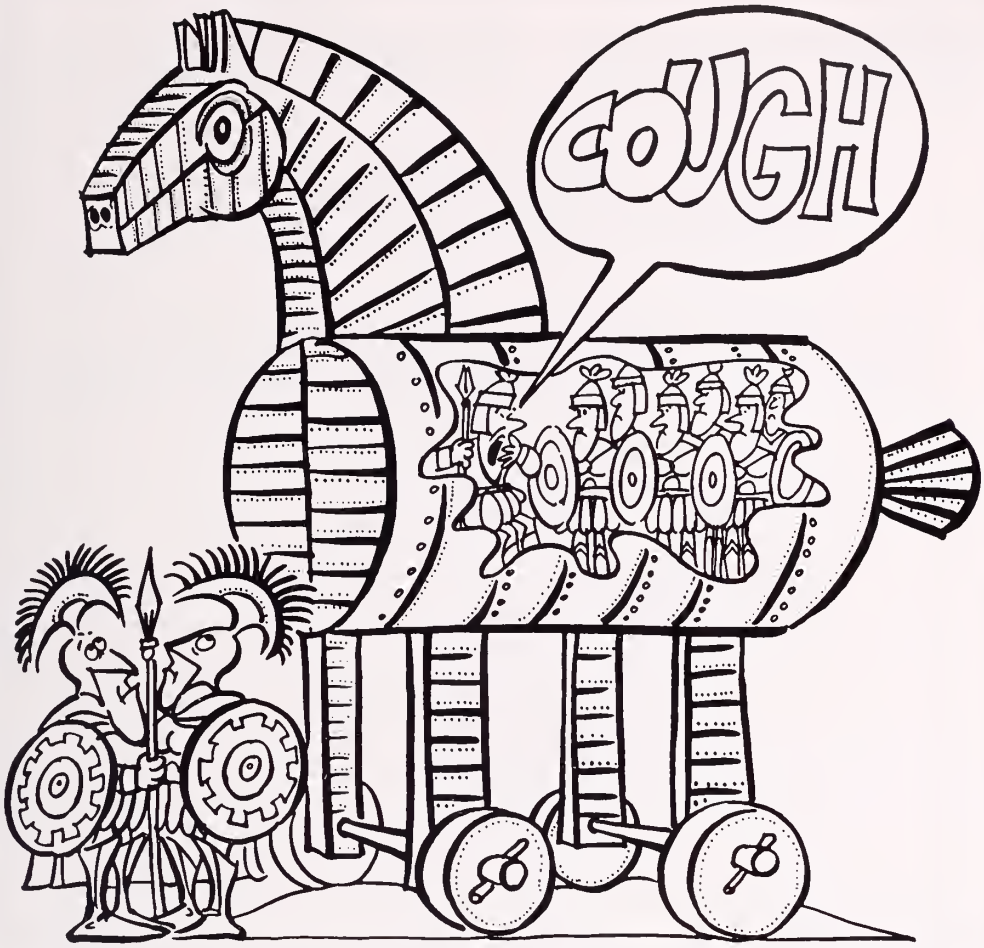
We know you knew him. And that you'll miss him.

We just don't want you to join him.

"Oops" is a pitiful epitaph.

National Safety Council

If you don't like thinking about safety, think where you'd be without it.



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Triaminic, 25 mg. (phenylpropanolamine hydrochloride, 12.5 mg.; pheniramine maleate, 6.25 mg.; pyrilamine maleate, 6.25 mg.); glyceryl guaiacolate, 100 mg.; alcohol, 5%.

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BO-SD

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"We are such stuff as dreams are made on"...

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Life would be pretty dull if people couldn't dream. Take that boat you're always dreaming about. Just thinking about it makes you feel pretty good. But you won't just have to dream if you buy U.S. Savings Bonds. Because Bonds can make your dream boat a reality.

Now Bonds mature in less than six years. Which means maybe it won't take forever for your ship to come in.

Just knowing you've got the safety and security of U.S. Savings Bonds working for you can make dreaming for anything a lot more fun. Because, with Bonds, the good times and the good things can really happen.

So, don't give up dreaming. Just keep buying U.S. Savings Bonds—they're the stuff dreams are made of.

Now E Bonds pay 5½% interest when held to maturity of 5 years, 10 months (4% the first year). Bonds are replaced if lost, stolen, or destroyed. When needed they can be cashed at your bank. Interest is not subject to state or local income taxes, and federal tax may be deferred until redemption.

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Take stock in America.

Now Bonds mature in less than six years.

100 Million Americans Covered By 'Catastrophic' Insurance

More Americans have more "catastrophic" health coverage than ever before, the Health Insurance Institute reported recently. This includes major medical expense coverage featuring benefits ranging from $10,000 to $250,000 per person—and higher issued through insurance companies.

These plans are geared to help pay for virtually all care—in or out of hospital—prescribed by a physician. Nationally, these plans insure about 80 million persons through insurance companies alone, with about 90 per cent of it through group policies.

Overall, including Blue Cross-Blue Shield plans and other plans, an estimated 110 million people in the U.S. are protected by some form of this coverage, says the Institute.

But exactly how extensive are the benefits provided?

According to a survey by the Health Insurance Association of America (HIAA), of 78 insurance companies insuring almost 67 million people, 4 out of 5 with group catastrophic plans have benefits of at least $20,000.

The survey also found:

Almost all insureds (97 per cent) have at least $10,000 in major medical benefits.

One out of every 5 has benefits of $250,000, or unlimited benefits, paying as much as it takes to get better.

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EXCEPTIONAL OPPORTUNITY—For an internist to become established in a progressive community of 50,000 by associating with an established, successful physician. Guaranteed annual income, fringe benefits, and option to form own practice after one year. Potential unlimited. Contact Mr. Michael F. Black, 5476 Big Tyler Road, Charleston, West Virginia (304) 776-2046.

PHYSICIAN'S PRACTICE FOR SALE — Well-equipped office of recently deceased physician is for sale and would be a most attractive opportunity for a family physician. Three treatment rooms plus a laboratory. Contact Mrs. Frank M. Muldoon, Salem, W. Va. 26426.

WANTED—Excellent opportunity for qualified obstetrician-gynecologist and pediatrican; office space, equipment, staff and excellent financial arrangements. Unlimited potential. Call Administrator "Collect" (304) 675-4340.

WANTED—A physician to take over the practice of an established physician in the community of Middlebourne and surrounding area of West Virginia. A fine opportunity with unlimited potential for an ambitious practitioner. Citizens in the area will do everything possible to help a new physician. Contact Mr. Philip B. Stealey, Secretary, Middlebourne Lions Club, Middlebourne, W. Va. 26149.

PHYSICIAN WANTED—An experienced practitioner to add to and work with an established group in Charleston. Excellent working conditions with regular hours and minimal night work. Liberal vacation, sick leave and holiday program. Pension plan, Social Security, and professional liability insurance coverage. Apply Charles E. Staats, M. D., 123 West Washington Street, Charleston, W. Va. 25302—Telephone 346-0381 Area Code 304.

WANTED—Internist urgently needed in a growing northeastern West Virginia community; drawing area is approximately 23,000; modern hospital with excellent facilities; office space available; guaranteed annual income; centrally located for vast recreational facilities. Write RLH, The West Virginia Medical Journal, P. O. Box 1031, Charleston, W. Va. 25324.

SURGICAL RESIDENCY AVAILABLE: Large metropolitan hospital, fully accredited for residency training. Contact Bert Bradford, Jr., M. D., Director of Surgery, Charleston Area Medical Center, 3200 MacCorkle Avenue, S. E., Charleston, W. Va. 25304.

WANTED—A physician to serve the area of Pennsboro in Ritchie County. A building to accommodate two physicians and one dentist has been completed. Citizens of Pennsboro guarantee that the physician will receive cordial reception and the area offers a wonderful opportunity for a young, ambitious physician. If interested, contact Mrs. J. Carl Rinehart, Pennsboro, W. Va.

WANTED—Physician desires relief work for one to four weeks. Experienced in coal fields and private practice. Phone: (304) 758-4918 or write Box 27, Middlebourne, W. Va. 26149.

WANTED—A general practitioner to locate in the growing town of Fort Ashby (Mineral County) West Virginia, situated to serve the communities of Short Gap, Springfield and Green Spring Excellent opportunity for an ambitious physician. For information on possible assistance in establishing office facilities, contact Doctor Committee, Fort Ashby Lions Club, Fort Ashby, W. Va. 26719.

WANTED—Emergency room physician in a teaching hospital. May develop any weak areas if you desire. Permanent position in a city of 25,000. Safe friendly area to live and bring up children. Annuity negotiable—based on academic and practical background. Send curriculum vitae before calling. Contact L. Perry Hyde, M. D., Director, Emergency and Ambulatory Care, Beckley Appalachian Regional Hospital, Beckley, W. Va. 25801. Phone: (304) 255-3000.

WANTED—General practitioner, internist, pediatrician and emergency room physician to associate with other specialties in small town in Southern West Virginia. Accredited 82-bed hospital and new clinic building. Excellent working conditions. Short-term appointments available. Contact Jorge J. San Pedro, M.D., Man, W. Va. (304) 583-6541.

EMERGENCY ROOM PHYSICIAN—Fully accredited 260-bed general hospital in the center of the Mid-Ohio Valley at Parkersburg, W. Va. Contact R. C. Cowan, Jr., M. D. Telephone 428-8011.

PHYSICIANS WANTED—Due to death and retirement, general practitioners and all varieties of specialists are needed in Clarksburg area. Financial help provided. Contact Dr. Herman Fischer, Recruitment Committee Chairman, 224 W. Olive Street, Bridgeport, W. Va. 26330.

PHYSICIAN'S OFFICE FOR RENT—Excellent opportunity for physician to relocate or for young physician to become established. Located at Big Chimney within minutes of Charleston. Modern ten-room clinic with new modern drug store nearby. For further information phone Charleston (304) 965-3240.

WANTED—Two general practitioners in Marlinton, Pocahontas County. A 42-bed general hospital is available. Successful practice practically assured and assistance will be offered in locating office space. Call Mr. S. E. Drumm, Administrator, Pocahontas Memorial Hospital in Marlinton, collect, for particulars (304) 799-4193.

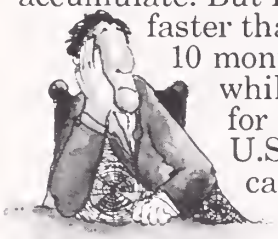
EMERGENCY ROOM PHYSICIAN — Accredited 280-bed progressive general hospital in beautiful Huntington, West Virginia; excellent income and working conditions; send resume to Assistant Administrator, Cabell Huntington Hospital, 1340 Sixteenth Street, Huntington, West Virginia 25701.

WANTED—Two general practitioners and a pediatrician to locate in a rapidly growing and extremely progressive community; excellent recreational facilities; within driving distance of the larger metropolitan areas; modern 45-bed general hospital, fully equipped and staffed; qualified general surgeon in residence. Write HRL, The West Virginia Medical Journal, P. O. Box 1031, Charleston, W. Va. 25324.

What's in it for you?

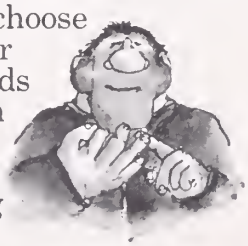
U.S. Savings Bonds are one way to take stock in America. And they're really a great way–because they do so much for you. U.S. Savings Bonds are full of advantages for the individual saver.

You don't have to wait forever for your money.
Any sizeable savings take a while to accumulate. But Bonds now mature faster than ever. (5 years, 10 months, to be exact.) So while they're still ideal for long-term plans, U.S. Savings Bonds can now work for your short-term goals.



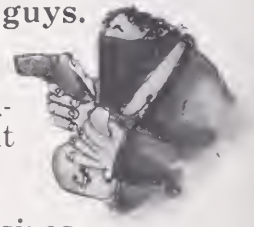
Our interest rate is nothing to scoff at.
E Bonds yield a healthy interest of 5.5% when held to maturity of 5 years, 10 months (4% the first year). And remember, there's a 10-year extension privilege beyond maturity for continued earning.

You have some options with taxes.
First of all, U.S. Savings Bond interest is exempt from all state and local income taxes. With federal income tax, you may choose to defer reporting your interest until the Bonds are redeemed or reach final maturity (whichever comes first). And if you're building funds for education or retirement, you have special tax-saving opportunities that are worth looking into.



If you need a shove to get you saving, we can do that too.
All you have to do is sign up for the Payroll Savings Plan at work. Then an amount you specify is set aside from your paycheck each month and used to buy Bonds. While you use your take-home pay for immediate needs, you're also building a nice nest egg. Automatically.

They're safe from bad luck, bad memory and bad guys.
Bonds are replaced if destroyed, lost or stolen. With no red-tape hassles. And at no cost to you.



They come in all sizes, but they fit everyone.
Bonds don't come with hearts or lace, but they offer a lot of hope, love and encouragement. For someone special, Bonds are a Gift Certificate of the Imagination.

U.S. Savings Bonds.
What it comes down to is taking stock in yourself.

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"We are such stuff as dreams are made on"...

W. Shakespeare

Life would be pretty dull if people couldn't dream. Take that boat you're always dreaming about. Just thinking about it makes you feel pretty good. But you won't just have to dream if you buy U.S. Savings Bonds. Because Bonds can make your dream boat a reality.

Now Bonds mature in less than six years. Which means maybe it won't take forever for your ship to come in.

Just knowing you've got the safety and security of U.S. Savings Bonds working for you can make dreaming for anything a lot more fun. Because, with Bonds, the good times and the good things can really happen.

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Take stock in America.

Now Bonds mature in less than six years.

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The Bactrim™ edge

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

A high assurance of clinical efficacy

- in cystitis, pyelonephritis and pyelitis diagnosed as chronic
- against susceptible strains of the common urinary tract pathogens, usually *E. coli, Klebsiella-Enterobacter, Proteus mirabilis,* and, less frequently, indole-positive proteus species.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Chronic urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Enterobacter, Proteus mirabilis,* and, less frequently, indole-positive proteus species).

Note: The increasing frequency of resistant organisms limits the usefulness of antibacterials, especially in chronic and recurrent urinary tract infections.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia in elderly patients on diuretics, primarily thiazides. Sore throat, fever, pallor or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted. Data are insufficient to recommend use in infants and children under 12.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, allergy or bronchial asthma; and in those with glucose-6-phosphate dehydrogenase deficiency, where hemolysis may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for children under 12.

Usual adult dosage: Two tablets b.i.d. for 10 to 14 days. For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	2 tablets every 24 hours
Below 15	Use not recommended

Supplied: Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 1000; Prescription Paks of 40, available singly and in trays of 10.

ROCHE

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Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Bactrim™

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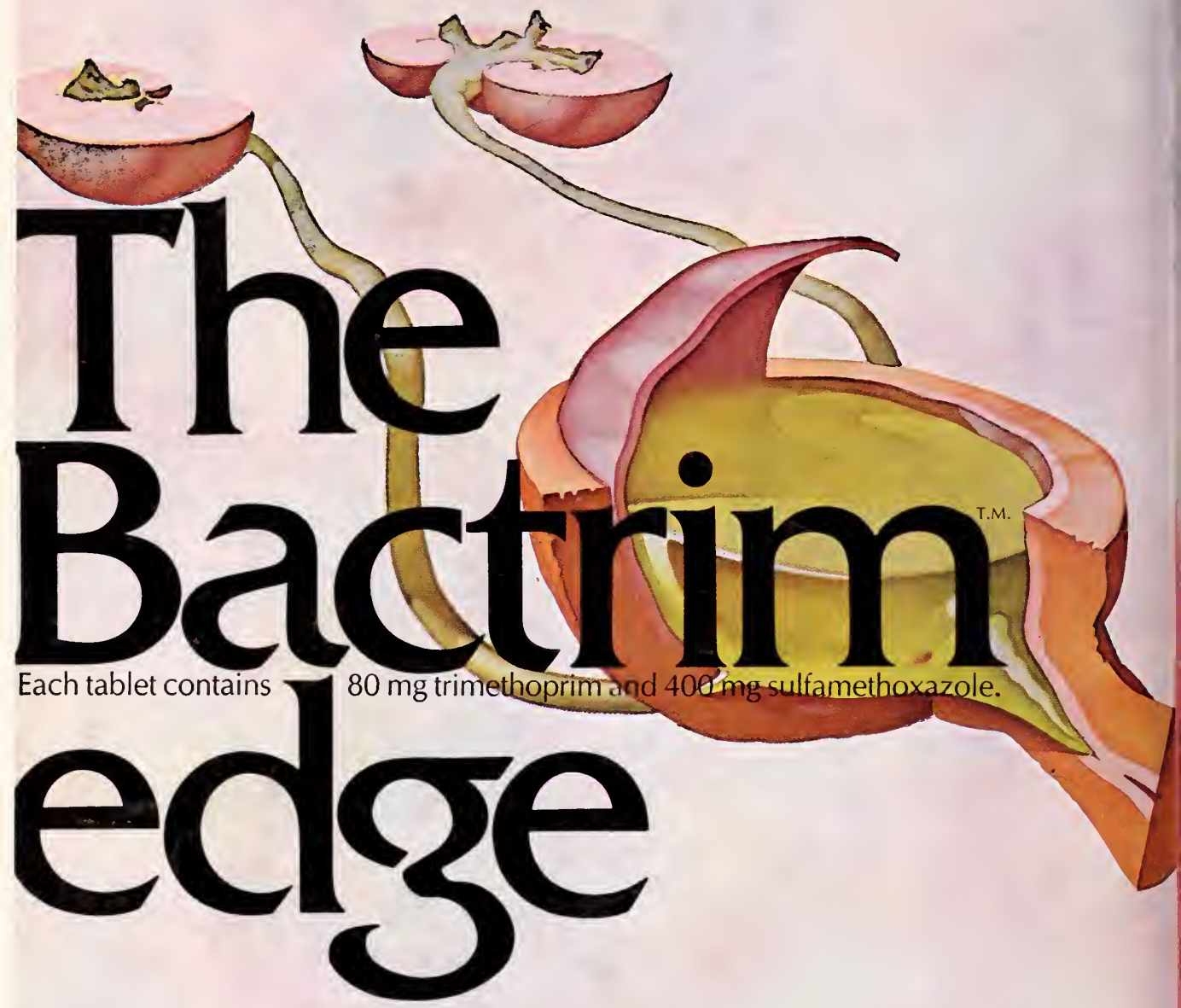

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

A high assurance of antibacterial activity
in cystitis, pyelonephritis and pyelitis diagnosed as chronic and due to susceptible organisms.

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the West Virginia Medical Journal

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Vol. 70 No. 9

8th Mid-Winter Clinical Conference
January 24-26, 1975

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SEPTEMBER 1974

Both often

Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

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primarily one of ex-
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depressive symptom-
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er than in a week or
two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

For further information on this subject, the following references are provided:

1. Henry BW, *et al: Dis Nerv Syst 30*:675-679, Oct 1969.
2. Hollister LE, *et al: Arch Gen Psychiatry 24*:273-278, Mar 1971.
3. Claghorn J: *Psychosomatics 11*:438-441, Sept-Oct 1970.

Valium® (diazepam)

2-mg, 5-mg, 10-mg tablets

in psychoneurotic anxiety states with associated depressive symptoms

ce because of their predisposi-
situation and dependence. In
, lactation or women of child-
ge, weigh potential benefit
ssible hazard.

ns: If combined with other psy-
s or anticonvulsants, consider
pharmacology of agents em-
ugs such as phenothiazines,
barbiturates, MAO inhibitors
antidepressants may potentiate
Usual precautions indicated in
everely depressed, or with latent
n, or with suicidal tendencies.

Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

SEPTEMBER
1974

Vol. 70 No. 9

The WEST VIRGINIA Medical Journal

Official Organ of the West Virginia State Medical Assaciatian

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Kids' Stuff
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9:30 A.M. and 2 P.M. Saturday, January 25
9:30 A.M. Sunday, January 26

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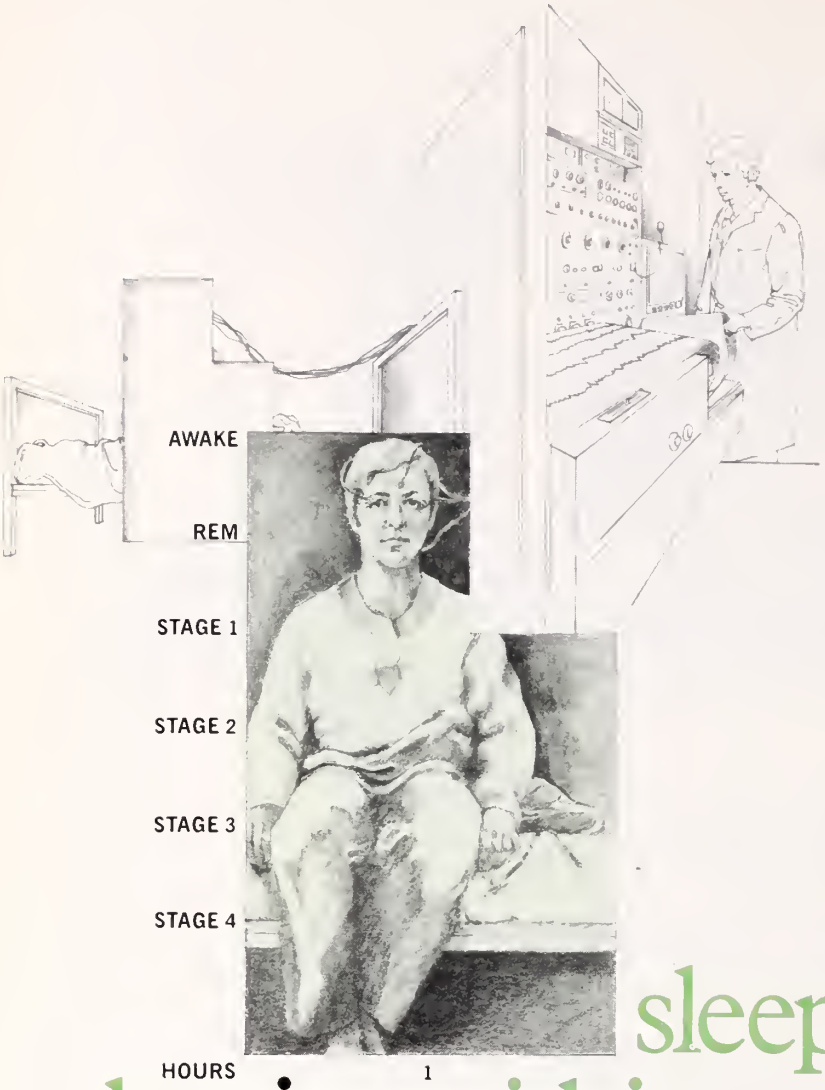

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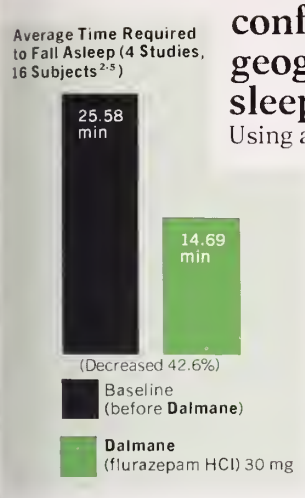

confirmed by clinical studies in four geographically separated sleep research laboratories[2-5]

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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.
Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.
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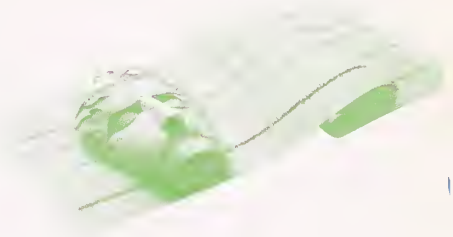

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REFERENCES: 1. Kales A, *et al*: *Arch Gen Psychiatry 23*:226-232, Sep 1970
2. Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington DC, May 3-7, 1971
3. Frost JD Jr: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
4. Vogel GW: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
5. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ

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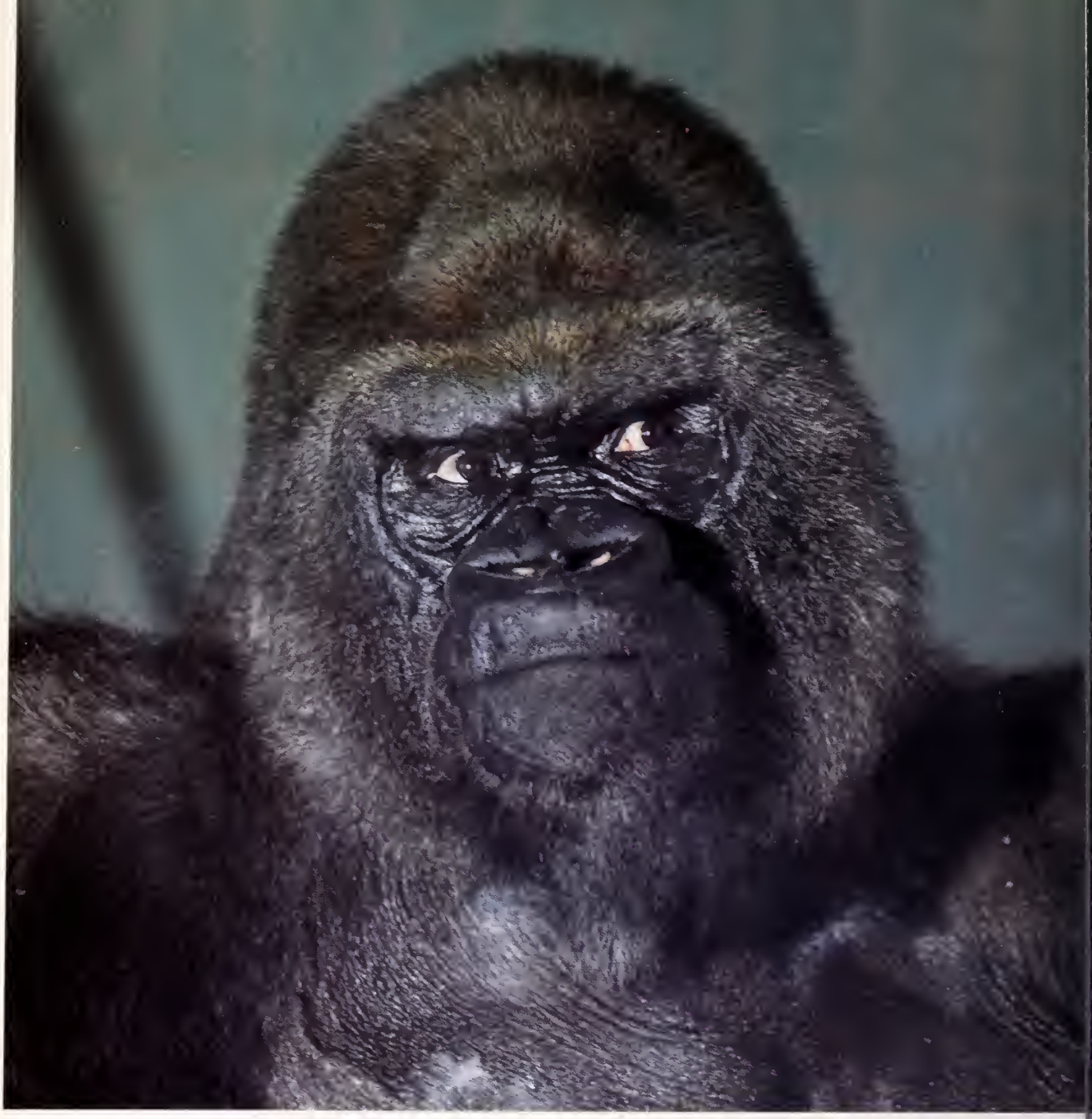

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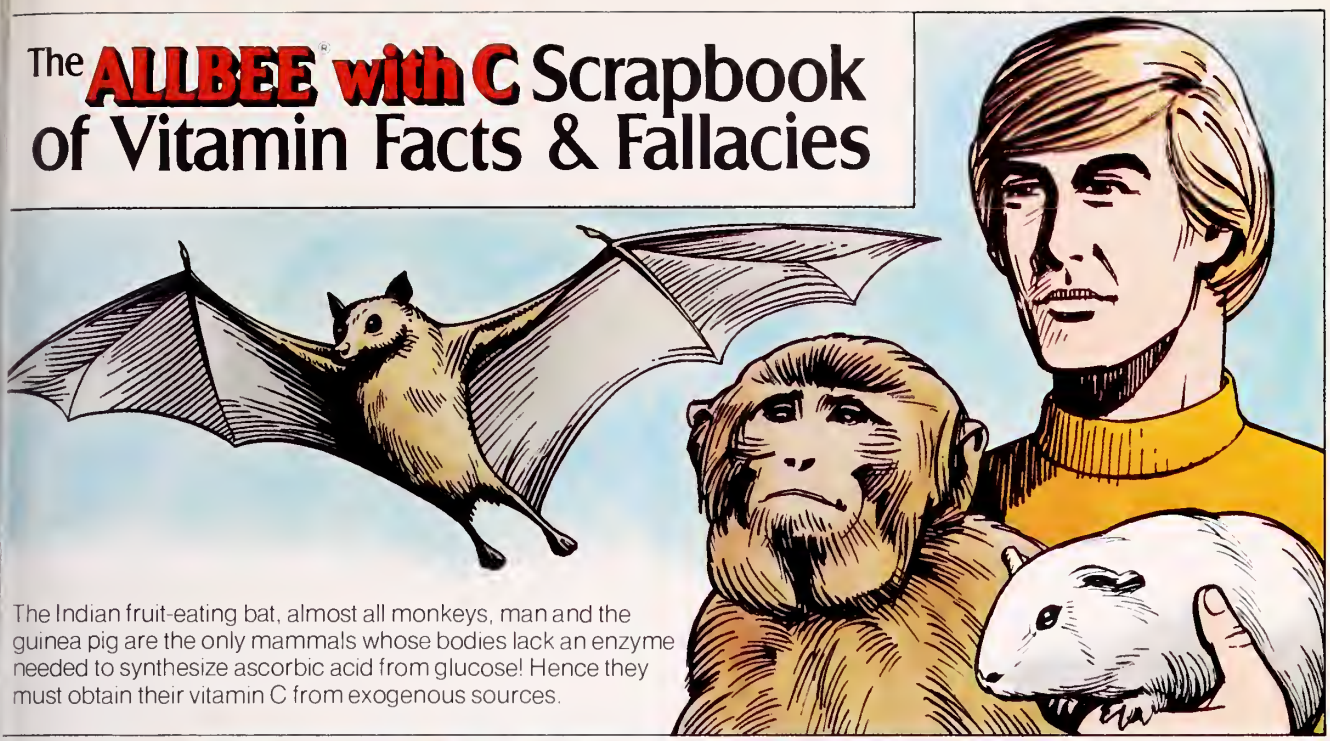
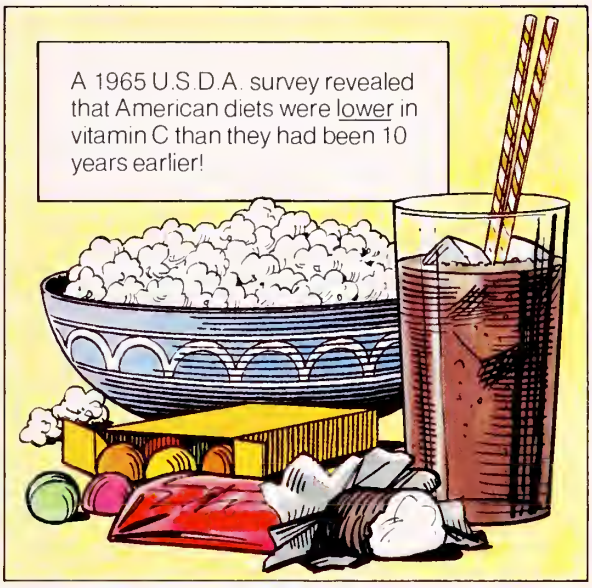


The Indian fruit-eating bat, almost all monkeys, man and the guinea pig are the only mammals whose bodies lack an enzyme needed to synthesize ascorbic acid from glucose! Hence they must obtain their vitamin C from exogenous sources.

De Joinville writing about a 13th century crusade reported that barber surgeons had to "cut away the dead flesh from the gums to enable people to masticate their food." The disease he described was probably scurvy.



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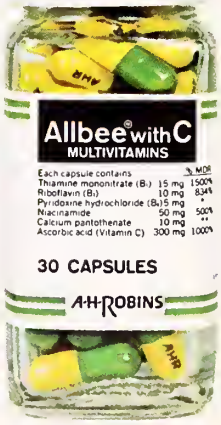

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The West Virginia Medical Journal

Vol. 70, No. 9 September, 1974

Hyperlipoproteinemia and Inner Ear Disease*

James T. Spencer, Jr., M. D.

Hyperlipoproteinemia has obtained its greatest clinical significance because of its high correlation with atherosclerosis and coronary artery disease. It now appears that the same metabolic dysfunctions manifested in hyperlipoproteinemia also contribute to altered metabolism and dysfunction in the inner ear. This paper is a further report of patients with inner ear disease associated with hyperlipoproteinemia (HLP). Of 444 patients evaluated by lipoprotein phenotyping, 207 cases, or 46.6 per cent, were found to have HLP; 46 cases, or 10.3 per cent, were borderline or presumptive; whereas 191 cases, or 43.1 per cent, were normal in this regard. Treatment of these patients by dietary management appropriate for the particular phenotype has resulted in symptomatic improvement in the majority of patients with dramatic gain or stabilization in hearing, cessation of vertigo, disappearance of recruitment, headache, fullness in the ears, and tinnitus. Clinical improvement is further evidenced by weight reduction as most of the patients were overweight. The elevated cholesterol and/or triglycerides also return to more normal values. On the basis of this study, it appears that hyperlipoproteinemia is a common metabolic disorder in otologic patients, early symptoms of which may be those of inner ear origin, frequently characteristic of labyrinthine hydrops or Meniere's disease.

The Author

- **James T. Spencer, Jr., M. D., Department of Otolaryngology, Charleston Area Medical Center, Charleston Clinical Division, School of Medicine, West Virginia University, Charleston, W. Va.**

Hyperlipoproteinemia is a common metabolic disturbance of the blood lipids, cholesterol and triglycerides, and their associated lipoprotein fractions.[1,2] It has been found to be present to some degree in over 50 percent of patients with inner ear disease,[3] many of whom present the complete picture of Meniere's disease. This high incidence of hyperlipoproteinemia in these patients and their most favorable response to dietary management with symptomatic improvement, suggests that hyperlipoproteinemia may be another — and a major — systemic affair, one or more aspects of which, adversely affect the predisposed inner ear, contributing to inner ear disease which in its fullest manifestation presents that clinical picture known as Meniere's disease.

The exact prevalence of hyperlipoproteinemia in the general population has not been fully determined but is reputed to be as high as 20 per cent. Its greatest clinical significance is its high correlation with atherosclerosis and coronary artery disease.[1,2]

The observations and impressions reported in this paper are based on an initially reported study[3] in a private otolaryngology practice, begun in August, 1971, and on the follow-up with additional patients now totalling 444 who have presented with symptoms of inner ear disease. It is believed that many patients with inner ear disease have symptoms insufficient in degree and number, and without all the accepted diagnostic findings, to qualify for the diagnosis of Meniere's disease, who nonetheless are all experiencing the same inner ear disorder, differing only in degree, stage of development, and rate of progression. Efforts to establish diagnostic criteria to clearly define fully developed Meniere's disease are believed to be largely

*Presented before the New England Otolaryngology Society in Boston, Massachusetts, on February 13, 1974.

academic, though important in the differential diagnosis from other disorders. As with coronary artery disease and atherosclerosis,[1] which have an excessive mortality, Meniere's disease, with its excessive morbidity, dysequilibrium, and hearing loss, will not be solved by further advances in the diagnosis and treatment of these terminal states, but by the early identification and preventive treatment of susceptibles in the community.

'Auricular Pathology'

Meniere's well known and original treatise[4] on "Auricular Pathology" has been recognized for his contribution in establishing the fact that episodes of "apoplectiform cerebral congestion," the common diagnosis in his time for episodes of vertigo, nausea, vomiting, tinnitus, and hearing loss, were actually, in his words, "functional disorders" of the "internal auditory apparatus" and were not of "cerebral" origin. Less attention has been given to his observations and comments concerning the etiology of this disorder. He observes that these episodes seemed "to be connected with appreciable causes" and "the obvious existence of certain cachexias." The exact meaning of the term "cachexias" intended by Meniere is subject to speculation, though he specifically mentions "syphilis" and the "rheumatic gouty state." However, the term cachexia suggests chronic disease, ill health or a constitutional or systemic disorder. Meniere further observes that increasing age or one's "years invariably bring on a certain amount of deafness," and "like the eye, the ear does not escape the changes supervening in our organs." He states that in addition to all of the inflammatory causes for deafness, "there are still many other hearing losses which relate in large measure to lesions which have their origin in the labyrinthine part of the ear." He then observes that "these alterations of the hearing are a natural consequence of the wear on the organs, but still more so of our abuse of them" and that "better hygiene would better protect us from this misery."

No one has more exhaustively tackled the problems of Meniere's disease than has H. L. Williams and his text[5] on the subject is a monumental reference. He gives credit to Mygind and Dederding[6] for suggesting in 1932, the first successful medical treatment for Meniere's disease, which now seems all the more significant, as it has certain basic features identical to the recommended treatment of hyperlipoproteinemia.

Mygind and Dederding stated that "Meniere's disease was not a disease, sui generis, but a typical reaction of the predisposed labyrinth to an almost infinite series of exogenous and endogenous influences which, however, have this in common, that they express themselves through increased capillary permeability." Their treatment consisted of advising weight reduction for overweight patients and weight gain for those underweight; in other words, maintenance of optimum body weight, which is basic in the treatment of hyperlipoproteinemia. They also recommend a restricted intake of fluids and sodium chloride. Their advice included physical therapy with exercise, heat and massage to promote vasomotor tone and correct an altered splanchno-peripheral balance. Three years of this regimen resulted in 80 per cent of 83 patients being free of vertigo, and 90 per cent with improved hearing. Twenty-nine years later, in 1961, Talbott et al[7] reported that high intakes of sodium chloride directly and adversely contributed to significantly high levels of serum triglycerides and fatty acids, while the levels of cholesterol and cholesterol esters fell.

Importance of Physical Exercise

Supporting Mygind and Dederding's exercise recommendations, according to Scarcy,[8] there has been in recent years a dramatic change in the view that carbohydrates are a major fuel used during aerobic muscular exercise. It is now recognized that oxidation of lipids plays a vital role in energy generation during muscular work.[9] Muscle cells contain enzyme systems for rapidly oxidizing long chain fatty acids to carbon dioxide and water.[10] Physical exercises therefore reduce the content of esterified fatty acids, mainly the triglycerides of muscle tissue, in the plasma, and in the liver.[11] It has also been shown that the degree and duration of serum lactescence following a fatty meal is lessened by vigorous exercise, possibly triggered by release of heparin into the circulation or activation of the lipolytic enzyme system.[12,13]

Williams[14] also reviews the clinical observations of Selfridge who considered that Meniere's disease might depend on a disorder of the peripheral vascular system, particularly capillaries. He points out that arteriolar spasm is likely to occur in individuals who have an unsteady autonomic system and is seen especially when there is a disturbance of factors related to the metabolism for carbohydrates and fats. Selfridge "pointed out that the internal auditory artery, being an end-artery, was particularly subject to vascular dysfunction in its terminals as are all end-arteries." In 1945, after an extensive review of the literature and

his own work, Selfridge concluded "that all the different components of the B-complex vitamins were involved in fat metabolism and that their lack in the diet, or the failure by an individual to absorb or utilize them in the absence of an endocrine factor, possibly the adrenocortical stimulating hormone of the anterior pituitary, might be responsible at once for fatty livers, an excess of cholesterol in the blood and a tendency toward vasospasm." It was his thought then that a vitamin B-complex deficiency might be a causative factor in the development of Meniere's disease that led to his prescribing a capsule before each meal containing thiamine chloride, riboflavin, pyridoxine, nicotinic acid, pantothenic acid, choline, inositol, and dried yeast powder. The similarity of the contents of this capsule to that contained in capsules of Lipoflavonoid® is striking.

References in the literature relating to metabolic aberrations and Meniere's disease are too numerous to cite them all. Shea[15] has presented fluctuant hearing loss as a cardinal symptom of inner ear disease caused or aggravated by one or more anatomic and metabolic disorders. He observes that in addition to the known and established obstruction of the endolymphatic duct and sac in the complete picture of Meniere's disease, there are various metabolic disorders known to be associated with or contributing to it. His study revealed 57 per cent of 70 cases with abnormal glucose tolerance, 7 per cent with hyperlipemia, 10 per cent to be excessive smokers, 10 per cent related to fluid retention, 7 per cent related to allergy, and 7 per cent related to anxiety.

In a recent study of 120 patients with Meniere's disease, Pulec[16] reports a specific etiology was found in only 36 per cent, 15 per cent on an allergic basis, 7 per cent due to syphilis, 6 per cent due to adreno-pituitary insufficiency, 3 per cent due to myxedema, 3 per cent due to stenosis of the internal auditory canal, and 3 per cent due to trauma. It is noteworthy that in Pulec's allergic group, 12 per cent obtained satisfactory control of their symptoms with a combination of therapy including thyroid replacement, allergic treatment, and a high protein, low carbohydrate diet.

Powers[17] reports a study of 98 patients with Meniere's disease in whom 30 per cent of 70 patients tested had abnormal five-hour glucose tolerance tests, 17 per cent of patients tested had clinically significant low thyroid function, and 33 per cent of 60 patients tested showed lowered adrenocortical reserve. Powers concluded that abnormal carbohydrate metabolism with hypoendocrine function appears to be a primary or contributing factor in Meniere's disease.

Allergic Excitation in Meniere's Disease

Powers[18] and Wilson[19] have both reported observations pertaining to allergic excitation in Meniere's disease particularly when the allergy is due to foods. It is rather significant that of the 14 most common foods found to be offending, all but four (lettuce, tomato, yeast and coffee) are potentially harmful to patients with hyperlipoproteinemia. These are wheat, beef (animal fat), pork (animal fat), chocolate (saturated fat), potato, corn, cow's milk, egg, malt, and orange. Powers states that in one-half of the patients in his study, placing the patient on a high protein, low carbohydrate, low fat diet, as treatment of the metabolic dysfunction was necessary in addition to treatment of hypersensitivity, before symptoms of Meniere's disease were completely controlled. As a guide, in the selection of patients with Meniere's disease who may also be candidates for an allergy survey, Wilson lists the following extra-labyrinthine symptoms: Fluid retention, nuchal myalgia, post - prandial fatigue, early morning insomnia, periodic mental depression or amnesia, and specific food cravings. All of these symptoms have been frequently observed in patients with hyperlipoproteinemia.

Weille[20] reported that some patients with Meniere's disease have evidence of hypoglycemia in five-hour glucose tolerance curves. He rationalized that a physiological insufficiency of adrenal glucocorticords contributed to increased insulin sensitivity, which reasoning he believed emphasized the need for a high protein, low carbohydrate diet in patients with Meniere's disease.

There may be some correlation of the various etiologic possibilities for Meniere's disease observed by these authors with hyperlipoproteinemia in that secondary causes of hyperlipoproteinemia include myxedema, the nephrotic syndrome, obstructed liver disease, diabetes, obesity, pregnancy, chronic renal failure, dysgammaglobulinemia, and the use of female sex hormones, particularly oral contraceptives.[1] Searcy [21] reports on several statistical studies which support a linkage between cigarette smoking, hyperlipemia and coronary artery disease. Administration of nicotine to experimental animals induces a rise in serum unesterified fatty acids as well as cholesterol.

In addition to the increased attention that abnormal lipid metabolism has had in its re-

lationship to atherosclerosis, there is evidence that an impairment in carbohydrate metabolism also exists.[22] Many patients with coronary artery disease exhibit hyperglycemia, glucose intolerance and exaggerated insulin responses to glucose loading. [23-25] It is established that insulin occupies a key position in the formation of lipids from carbohydrates. Almost invariably there is an accelerated production of insulin associated with endogenous hyperlipoproteinemia.[26] A high percentage of these patients are reported to demonstrate elongated, tortuous, dilated, engorged, venular limbs, frequently accompanied by hemorrhages resembling diabetic microangiopathy, all of which subside when excessive hyperlipemia is controlled.[27]

It is reported that there may be some link to the number of mask cells in the body, as they are a source of heparin. Heparin and lipoprotein lipase activity are thought to play roles in the disposition of circulating lipids, in that there is an inverse relationship between plasma heparin levels, circulating cholesterol, and low-density lipoproteins. [28-30]

It has been recognized since 1845, that there is a gestational hyperlipidemia in pregnancy.[31] Beginning with the second trimester, the cholesterol fraction increases significantly and triglycerides are especially elevated. Oral contraceptives result in a decrease in post-heparin lipolytic activity, and this same decrease occurs in late pregnancy when estrogen levels are high. Some alteration in carbohydrate metabolism would also seem to be at play in pregnancy in view of the known relationship between triglycerides and carbohydrate metabolism.[32]

In this study of 444 cases, symptoms of inner ear disease were found to be cochlear and/or vestibular, and often associated with cranial symptoms. The primary cochlear symptom was a sensori-neural hearing loss which may be progressive, fluctuating or sudden in onset. The configuration of the pure tone audiograms frequently showed the fluctuating low tone slant or rising curve with a non-fluctuating high tone slant above 2000 Hertz. Many showed a more pronounced falling curve with a greater high tone loss. There are many with a variable flat curve. Many show a predominantly unilateral loss, but usually with some changes in the opposite ear. Speech discrimination scores were usually lowered if there was a significant pure tone loss, but the configuration of the pure tone audiogram has been found to be the most helpful diagnostic feature of the audiometric evaluation. Associated symptoms and findings include loudness recruitment, diplacusis, tinnitus, fullness in the ears, and discomfort or pain in the ears. Vestibular symptoms are evidenced by disturbed equilibrium with acute vertiginous attacks, positional vertigo, or a more vague lightheadedness. There may be staggering between episodes. Nausea and vomiting frequently accompany the more acute episodes. Cranial symptoms are frequently a pressure feeling in the head or a tightness, or a sense of the head feeling "big." Headaches may be present, either generalized or localized, often occipital with a cervical component.

These patients have been frequently observed to be overweight to some degree, and some decidedly obese. They frequently lack ability to lose weight easily or permanently, and tend to gain weight easily. Not uncommonly they crave sweets and carbohydrates. They may be known to be diabetic, pre-diabetic, or have been warned of this danger. There may be a family history of diabetes or atherosclerosis with coronary artery disease. They often complain of or admit to being tired, lacking in energy, commonly experiencing drowsiness, especially after meals. Some are despondent, some are irritable. Sleeping habits are frequently poor. When hyperlipoproteinemia is of long standing, they may show xanthelasma of their eyelids, arcus corneae, xanthomata, either erruptive, tuberous, or palmer. Their eyegrounds may show lipemia retinalis.

Representative case studies have been previously reported. Among these cases are patients with sudden deafness, many with the typical early labyrinthine hydrops with fluctuating hearing loss, long-standing unilateral Meniere's disease, initial onset of acute Meniere's disease, progressive sensori-neural deafness of all degrees, hydrops in women taking the "pill," acoustic trauma, otosclerotics with hydrops symptoms, compensation cases with hearing loss and/or vertigo, recurrence of Meniere's symptoms following an endolymphatic shunt operation, and many with only a single complaint such as tinnitus in one ear, fullness in an ear, slight vertigo, or hearing loss of all degrees in one or both ears.

Lipoprotein Phenotyping Studies

All of the 444 cases were evaluated for hyperlipoproteinemia by lipoprotein phenotyping studies, a battery of tests which includes a serum cholesterol, serum triglycerides, and electrophoretic evaluation of the lipoproteins with quantification of the lipoproteins by densitometry. The blood is drawn in the morning after a 14-hour overnight fast. Frequently, a glucose

tolerance test is done the same morning. In this study of 444 cases, a total of 207 cases, or 46.6 per cent were found to have hyperlipoproteinemia, 46 cases or 10.3 per cent were borderline or presumptive, whereas 191 cases, or 43.1 per cent were normal in this regard. An elevated glucose tolerance was demonstrable in 87 per cent of the hyperlipoproteinemia cases that were tested, being either overtly diabetic, mildly diabetic, or pre-diabetic. Obesity was present in over 80 per cent of cases. Two-thirds of patients who did not show hyperlipoproteinemia and had glucose tolerance tests performed showed decreased glucose tolerance. It is especially noteworthy that there were seven IILP patients, or 3 per cent, with a history of Bell's palsy. On evaluating an additional nine patients with Bell's palsy not in this original study, but making a total of 16, there were nine with hyperlipoproteinemia and two diabetics.

Hyperlipoproteinemia consists of five clinical Types – Types I, II, (IIa and IIb), III, IV, and V.[1] In this study there were one Type I, 34 Type IIa, 16 Type IIb, two Type III, 164 Type IV, and no Type V. The clinical significance and diagnosis of each type, as well as their treatment, depends on knowing and understanding the lipoprotein alterations for each type along with the values of the serum cholesterol and serum triglycerides.

Type I is very rare and shows an extremely high triglyceride value with very high chylomicrons with a normal beta and pre-beta pattern. Sub-Type IIa is a common type and primarily a hypercholesterolemia and is associated with elevation of the beta lipoproteins. Sub-Type IIb differs from IIa in that the triglycerides are moderately elevated along with the pre-beta lipoproteins. The less common Type III is similar to Type IIb, but differs in that both lipid values are very high and the electrophoretic pattern shows a "broad beta" band fusing with the pre-beta band. Type IV is a very common type and characterized by elevation of the triglycerides and an elevation of the pre-beta lipoproteins, while the cholesterol value may be normal or slightly elevated. Type V is quite uncommon, similar to Type IIb, but with the presence of elevated chylomicrons.

Reliance entirely on the values for the electrophoretic pattern for the final determination of the clinical type can lead to error. The electrophoretic pattern can often be atypical and misleading. When there is doubt, one must be guided by the lipid values, the appearance of the serum after standing overnight in the refrigerator, and by the clinical features of the patient.

In actual practice, the majority of patients can be easily diagnosed and clearly defined as to type. Most hospital laboratories are not set up to do electrophoretic studies on the lipoproteins, and usually depend on the larger commercial laboratories to do these studies. However, not all commercial labs do densitometry and therefore their reports do not give a quantitative value for the lipoproteins. In these instances, it is then necessary to depend on the laboratory and your own subjective interpretation of a copy of the electrophoretic pattern. In this study, lipoprotein phenotyping has been done routinely in conjunction with the determination of the serum cholesterol and triglycerides on patients who have fasted overnight for 14 hours following their evening meal. Since the phenotyping electrophoretic study on the lipoproteins is needless when lipid values are normal, it is recommended that the laboratory be requested to do phenotyping only if one or both of the lipid values are above a pre-determined normal value, thereby reducing the expense to the patient. Biochemical Procedures Laboratory in Los Angeles, has a Lipo-Tec® kit that accomplishes this just as described.

A word might be mentioned at this point about normal and abnormal cholesterol and triglyceride values. It cannot be stated when a specific lipid value has shifted from a normal to a pathologic level. However, according to Fredrickson and Levy,[33] an obvious hyperlipidemia requiring diligent management exists when values of cholesterol are above 230 mgm. per cent for anyone under 19 years of age and when over 330 mgm. per cent for anyone over 50 years of age. Triglyceride values are abnormal when above 150 mgm. per cent for anyone under 19 years of age and when over 200 mgm. per cent for anyone older. It is pointed out that the limits set by these values just mentioned are not safe or adequate in general clinical practice. Epidemiological data have shown that individuals with cholesterol concentrations below the values mentioned still have an increased risk for premature coronary artery disease and, on the basis of experience in this study, this is true for patients with inner ear disease. We are advised, therefore, by Fredrickson and Levy that hyperlipidemia deserving some attention may exist when cholesterol exceeds 220 mgm. per cent or when triglycerides exceed 150 mgm. per cent for all patients under age 55. All individuals with values above these levels merit attention as to their general health, family history,

way of life, dietary habits, weight control and alcohol intake.

Dietary Management

Dietary management is the cornerstone of therapy for patients with hyperlipoproteinemia.[1] Diet therapy needs to be understood by the physician as he will bear the responsibility for seeing that it is also clearly explained to the patient. In patients with hypercholesterolemia, alterations in the diet are designed to reduce cholesterol values and this is accomplished by restricting the intake of saturated fats as present in meat, dairy products and eggs. Elevated triglycerides derive their source primarily from refined sugars, concentrated sweets, starches and carbohydrates in general. In most incidences, patients with elevated triglycerides are overweight, more so than patients with elevation of cholesterol.

In any case, weight reduction to ideal body weight is essential and its accomplishment is one indication of satisfactory dietary management. "A Handbook for Physicians"[33] on "The Dietary Management of Hyperlipoproteinemia" is available from the Office of Heart and Lung Information, National Heart and Lung Institute, National Institutes of Health, Bethesda, Maryland 20014. In this handbook, the specific diet for each type is clearly defined. Copies of each diet are also available to give to individual patients.

The essential features of the dietary management are: (1) the reduction of cholesterol intake by reducing or elimination of the intake of saturated fats, while at the same time, substituting an increased intake of polyunsaturated fats; (2) the reduction of triglycerides by controlling carbohydrate intake and eliminating entirely all sugars and concentrated sweets; (3) achieving and maintaining "ideal body weight." The hyperlipoproteinemia "type" determines to what degree each of these features apply in a given patient. Diet is effective when weight reduction follows and lipid values return to normal, and hopefully, symptoms regress or disappear.

Results of Dietary Management

Symptomatic improvement in response to dietary management has occurred to some degree in the majority of patients who sufficiently adhere to their diets to experience a weight loss when indicated and/or a lowering of their abnormal lipid values. In some, the improvement has been dramatic in a matter of four to eight weeks on their diet in that it is the first lasting symptomatic improvement they have experienced in years of their disease.

Phenomenal gain in hearing has resulted with as much as a 30 decibel improvement in an affected ear. A fluctuating hearing loss fluctuates less and often stabilizes at an improved level. The recruitment disappears along with the fullness and discomfort in the ears. Acute vertiginous attacks cease or become much less frequent and severe. Headaches, pressure in the head and fullness in the ears are among the first symptoms to be relieved. In addition to these improvements, these patients generally improve in appearance from weight loss, exhibit or admit to having more energy, and feel more youthful. They are very grateful patients.

The established high correlation of hyperlipoproteinemia with atherosclerosis, and now, the seeming correlation of hyperlipoproteinemia with inner ear disease and hearing loss adds further significance to the epidemiological studies of Rosen,[34-40] relating hearing loss to coronary artery disease in those population groups where there is a high incidence of atherosclerosis and a high intake of saturated fats. Because of the high incidence of hyperlipoproteinemia, and the potential of coronary artery disease and atherosclerosis in patients with inner ear disease, with a two-fold purpose in mind, these patients should have as part of their total evaluation, determinations made of both their serum cholesterol and triglycerides following a 14-hour fast, with lipoprotein phenotyping if either or both lipid values are elevated.

It now appears that the same metabolic dysfunctions that lead to the development of atherosclerosis and coronary artery disease also contribute to malfunctioning of the cochlear and vestibular labyrinth. Long before there is gross occlusive vascular disease, there are apparently abnormal biochemical humoral changes preceding and affecting the cellular metabolism in many of the body's specialized organs. The predisposed inner ear, being highly specialized, infinitely small, and microscopic in detail, reasonably would be expected to reflect as a local manifestation the presence of a systemic metabolic dysfunction such as seen in diabetes and hyperlipoproteinemia.

Disabling Meniere's disease is not life threatening as is atherosclerosis. However, on the basis of current knowledge regarding hyperlipoproteinemia, any patient that might be suspected of being a candidate for hyperlipoproteinemia on the basis of his own personal medical history or positive family history should have the recommended lipid studies. Indeed, it appears that symptoms of inner ear disease may occur much earlier, as a forerunner, in many

patients who may manifest symptoms later in life of coronary artery disease or atherosclerosis.

The early diagnosis of hyperlipoproteinemia, so readily controlled by diet, the cornerstone of treatment, serves to identify a metabolic alteration that appears to be a significant etiologic factor in the development of inner ear pathology. Also, by early diagnosis and dietary management, the development of atherosclerosis may be prevented, arrested or minimized. An "otologic finger" now points to the need for early detection of patients with hyperlipoproteinemia who have high risks for atherosclerosis and coronary artery disease, and also for hearing loss and vestibular dysfunction.

Joint Statement on Diet and Coronary Artery Disease

The Council on Foods and Nutrition of the American Medical Association and the Food and Nutrition Board of the National Academy of Sciences have made a joint statement on diet and coronary artery disease which stresses that the average level of the plasma lipids of most American men and women is undesirably high and that reasonable means must be adopted to reduce the conditions that contribute to coronary artery disease. They emphasize that sufficient evidence is now available to discourage further temporizing with this major national health problem, and that dietary modifications which do influence serum cholesterol and triglyceride levels, must now be considered important preventive and therapeutic meaures. Moreover, they point out that it is possible to plan changes in diet which are palatable, effective, economically feasible, nutritionally sound, and applicable throughout most of one's life.[41]

Hilger, upon making his commentary before the symposium dealing with "The Vestibular System and Its Diseases" in 1965, implied that Meniere's disease is not a single entity, but rather a non-specific response of labyrinthine tissues to a variety of systemic faults.[42] Hyperlipoproteinemia appears to be just such a fault, a very common one, and one the diagnosis of which may be more significant for the patient than the diagnosis of labyrinthine hydrops, Meniere's disease, nerve deafness, or Bell's palsy.

Summary

It is gratifying that the treatment is primarily a dietary one that cannot help but provide a better balanced diet that is more nutritionally sound. While treating the patient's inner ear disorder, simultaneous improvement in their general health and increased longevity can be expected to follow.

Derlacki[43] has characterized the present-day treatment of Meniere's disease as a prime example of the art of medicine. There is still a great need for some of this art even in the Meniere's patient with hyperlipoproteinemia, but what a relief it is to sense the possibility of becoming a bit more scientific in the treatment and the prevention of this disorder.

A list of references may be obtained by writing The Journal.

Requests for reprints should be sent to James T. Spencer, Jr., M.D., P. O. Box 1628, Charleston, W. Va. 25326.

A man of courage is also full of faith.

CICERO

Annual Report of the Committee on Maternal Welfare

A meeting of the Maternal Welfare Committee of the West Virginia State Medical Association was held at the Heart-O-Town Motor Inn in Charleston on Sunday, October 28, 1973. Those in attendance were Clarence H. Boso, M.D., Acting Chairman, and the following members: Larry D. Curnutte, M.D.; T. Keith Edwards, M. D.; Edwin J. Humphrey, M. D.; Rose H. McClanahan, M.D.; and Frederick H. Dobbs, M. D., Secretary.

The Chairman expresses his appreciation for the splendid cross-section of physicians available for this important study. The members attending the meeting represent a hard core of interested obstetricians who are professionally qualified to review the case abstracts and to understand the facts contributing to each maternal death and to make intelligent recommendations for the benefit of the interested physicians and for the edification of the physicians who practice obstetrics in the State.

The Committee is extremely grateful to the interested physicians who are involved in maternal deaths that they take time from their busy practices to complete a detailed questionnaire, forward copies of case histories and copies of autopsy reports. The Administrators and Record Librarians also are to be commended for their cooperation in forwarding complete case records on the maternal deaths.

The data obtained from the different sources is abstracted as a hypothetical case and the name of the patient, the interested physician and hospital are confidential and not available to anyone except the Secretary and his departmental secretary. All sources of information are used to determine a sudden demise in a complicated delivery and are obtained from the patient's chart, the doctor's notes, the resident's history and especially the nurses' notes.

The Bureau of Vital Statistics, under the direction of Dr. N. H. Dyer and Mr. Paul Shanks, is the primary source of our maternal death information. The death certificates of all women in the childbearing age are checked by a special clerk in the Bureau and any death certificate having any relationship to pregnancy is photostated and referred to the Secretary for his scrutiny. If the certificate is classified as a maternal death the proper letters are written and a questionnaire forwarded to the physician. In borderline cases a letter is written for clarification.

The Secretary reported that there are prenatal and delivery services available for indigent families in 30 counties of the State and there were 700 deliveries authorized for the fiscal year. This is a state-supported clinic effort and the number of deliveries are limited by the amount of budget money available to the Department. Family planning clinics are established in 43 counties with a total of 87 clinic sessions in one year and a total of 14,504 patients on the program. This reflects the trend of our times in the establishment of additional prenatal and delivery service clinics and the expansion of family planning clinics to more than three fourths of the counties in the State.

Following the business portion of the meeting, the Committee then proceeded to the study of 19 abstracts of maternal deaths available at this time.

Case No. 335—RUPTURE OF THE UTERUS—FOLLOWING STIMULATION OF LABOR WITH AN OXYTOXIC DRUG.

A white married female, age 31, Gravida 3 Para 2 was admitted to the hospital in active labor. The patient was 42 weeks in her third pregnancy and the condition upon hospital admission was considered fair only. At the time of admission the patient was passing copious amounts of meconium and amniotic fluid and the fetal heart sounds were synchronous with the radial pulse. There was no positive evidence of a viable fetus. After admission she received the usual preparation and laboratory procedures. Labor began spontaneously at home with irregular contractions and spontaneous rupture of the membranes. At 7:55 P.M. she was admitted. At 8:15 P.M. the cervix was dilated 3 cm. and 70 per cent effaced but the contractions were irregular and not of good quality. At 10:30 P.M. dilitation was the same so she was given buccal pitocin and Vistaril 50 mg. I.M. At 11:00 P.M. buccal pitocin repeated and the contractions became stronger and regular but the dilitation remained the same. At 12:30 A.M. the patient vomited. At 1:15 A.M. dilitation 4 cm. and 80 per cent effaced. Nisentil 30 mg. I.M. At 1:50 A.M. dilitation 9 cm. 95 per cent effaced and the patient vomited a small amount of green fluid. Given Atropine 1 c.c. At 2:00 A.M. complete dilitation. Received Nisentil mg. 30 I.M. and removed to the delivery room where an M.D. anesthetist administered Cyclopropane. At 2:12 A.M. the patient delivered a stillborn male fetus weighing 5 pounds over a medium episiotomy with low outlet forceps. At 2:14 A.M. the placenta delivered demonstrating many infarets and the maternal surface was

smooth and heavy with maternal blood. She passed double handfuls of clots behind the head during delivery. The fetus demonstrated the classical signs of being stillborn with overriding of the cranial bones and collapse of the umbilical cord. With the delivery of the placenta the pressure dropped to 90/0 and during the repair dropped to 50/0 and remained at that level until she expired. While waiting for whole blood she received 1000 c.c. glucose 5/W with stimulatory medication. At 3:35 A.M. blood started at a rapid rate but in 10 minutes she stopped breathing. Closed cardiac massage and then open cardiac massage was instituted but to no avail. The heart was found to be empty.

At autopsy, there was a purplish-blue area of retroperitoneal hemorrhage on the left which surrounds the urinary bladder on the left pushing the posterior peritoneum between the bladder and the psoas muscle anteriorly. The retroperitoneum of the fallopian tube and left ovary is pushed anteriorly and contains an irregular feathery large area of disruption in which the ovarian and the uterine arteries are visible as irregular jagged stumps. At this point further reflection of the retroperitoneum reveals that the entire left side of the uterine corpus contains a jagged hemorrhagic rupture which extends from the level of the internal cervical os up to the isthmic portion of the left fallopian tube.

Comment: The Committee reasoned that stimulation of a multigravida uterus with buccal pitocin contributed to the uterine rupture and after the uterus had ruptured there was no emergency measure possible to prevent death from such an extensive rupture. Because buccal pitocin levels are not possible to measure, this patient might have been sensitive to the drug causing violent contractions with the subsequent rupture. They feel that buccal pitocin should not be used at any time and use only very dilute solutions of I.V. pitocin by the attending physician who is present at all times during the administration.

Case No. 342—CARDIAC ARREST IN A MULTIGRAVIDA 42 WEEKS GESTATION WITH SEVERE TOXEMIA DELIVERED BY CESAREAN SECTION USING SPINAL ANESTHESIA.

A black married female, age 27, a Gravida 8 Para 7 with five living children was admitted for the treatment of a severe toxemia. Her blood pressure averaged 150/90 but she had considerable edema and gained 25 pounds in the last trimester of the pregnancy. Albumin was present in the urine specimen. She was treated in the hospital for 12 hours with no improvement of the toxemia. A general surgeon was consulted who approved the section and proceeded to operate. The patient received cedilanid I.V. before surgery, and she was given a spinal with Pontocaine 13 mg. As soon as the spinal anesthesia had been administered the blood pressure dropped rapidly. Ephedrine was given but she developed cardiac arrest. External cardiac massage was given and the abdomen was opened up and internal cardiac massage was given but no response. The fetus was delivered by section but it was in arrest. All efforts to revive both of them failed. The fetal death was attributed to uterine asphyxia. There was no autopsy.

Comment: While the recorded levels of hypertension were not high, the patient had the other signs of toxemia, with severe edema, albumin in the urine and general disability. The Committee attributed this death to the anesthesia. They felt that cedilanid should not be given in toxemia before a spinal anesthetic and that a spinal is not indicated in severe toxemia because of the tendency of the blood pressure to drop rapidly after its administration. They also questioned the amount of drug administered feeling that a 13 mg. dose of Pontocaine was excessive.

Case No. 343—ECLAMPSIA IN A 37 WEEKS PRIMIGRAVIDA, WHO WAS EXTREMELY OBESE.

A white married female, age 24, a Gravida 1 Para 0, who was 37 weeks in her first pregnancy was admitted to the hospital after suffering a convulsion at home. Her condition upon hospital admission was considered grave. The patient developed severe preeclampsia two weeks before admission, with hypertension up to 250/160, marked edema, albuminuria and severe headaches. Office therapy carried out at home did not improve the condition and upon the day of admission she had a convulsion at home. Her weight at the beginning of her pregnancy was 270 pounds but there is no recorded weight for the next 30 weeks and it is assumed she must have gained from 20 to 30 pounds considering the edema at admission. The patient was admitted on October 17, 1971, 37 weeks in her first pregnancy, a blood pressure of 250/160, with headaches and all the signs of severe toxemia of pregnancy. The vertex presented but the head was floating, the cervix soft and only a finger-tip dilated. She received Phenobarbital, Esidrex; MgSo4 deep in each buttocks; Reserpine; Serpasil; Intake and output; salt free diet and complete bed rest. An hour after admission she had a convulsion. The blood pressure fluctuated between 220/110 and 260/130.

October 18, 1971: Salt free diet. BP 208/122. At 10 P.M. an amniotomy was performed with a large amount of meconium expressed. A Foley catheter was placed in the bladder and a pitocin drip started and continued for 40 minutes. The blood pressure became elevated to 230/140 to 300/150. The patient became restless and attempted to get out of bed. A surgical consultant agreed to a section and a classical cesarean section was performed with the delivery of a viable female fetus which survives. The first post operative day was uneventful with

the blood pressure ranging from 160/110 to 170/130. But on the second postoperative day she developed a diarrhea and a slight temperature, and this combination of complications continued for the next eight days, when she finally went down hill slowly and on the second day before her death, had convulsions and on the 10th postoperative day she continued with frequent and constant convulsions and finally died. There was no autopsy.

Comment: Several factors of preventability were considered by the Committee. First; the Committee felt that cesarean section immediately upon admission was the treatment of choice. An hour after admission she had another convulsion. Second: The following day an amniotomy was performed and intravenous pitocin started. The admission examination revealed the vertex to be floating and no signs of labor. The blood pressure reached its highest elevation of 300/150 when the pitocin was discontinued. The patient exhibited signs of cerebral irritation and attempted to get out of bed. It was here that the section was considered and performed. However, the Committee felt that she had a severe potassium deficiency with a severe electolyte imbalance and once the diarrhea started with the endometritis, with fever, the attempts to control the diarrhea and temperature were hopeless.

Case No. 347—RHEUMATIC HEART DISEASE WITH HEART FAILURE IN A SEVEN MONTHS PREGNANCY.

A white married female, age 26, a Gravida 2 Para 1, was admitted to the hospital with an extensive bronchopneumonia. The patient was approximately seven months in her second pregnancy and the condition upon hospital admission was considered grave. The patient had prenatal care from an obstetrician in another city, but she became desperately ill and was taken to the emergency room of her local hospital. Two days prior to admission she was treated at another hospital in the area, with penicillin injections and sent home. The present admission was characterized by acute respiratory distress, blood tinged productive cough, associated with back pain, retrosternal pain and severe dyspnea. Her past medical and surgical history reveals she had rheumatic heart disease wtih valvular damage and cardiac surgery for the correction of a mitral valve stenosis in 1946. She was a Gravida 2 Para 1 and had a previous cesarean section in 1967 (etiology unknown).

Upon admission the blood pressure was 140/80, pulse 110. The physical examination revealed the heart enlarged in its border with a pan-systolic murmur all over the precordium. There is a marked tachycardia. The patient was markedly obese but the weight was not documented. There is bronchial breathing in both lung fields with inspiratory crackling rales associated with wheezing. The breath sounds are diminished in the left lung field. The hemoglobin is 11.8 grams, hematocrit 37 grams per cent; W.B.C. 20,600; and the differential; immature neutrophiles 16 per cent; mature neutrophiles 75 per cent; and lymphocytes 9 per cent. Urinalysis was normal except for a large amount of acetone.

Hospital course consisted of complete bed rest, Ampicillin intravenously, continuous oxygen and in spite of the therapy she continued a downhill course. The cyanosis noted on admission deepened, and four hours after admission she was started on digitalis because of congestive failure. Eleven hours after admission she went into cardiac arrest and cardiac resuscitation was instituted but this was not successful. A postmortem cesarean section was done but in spite of resuscitation the infant did not survive. There was no autoposy.

Comment: The direct obstetric cause of death was a seven months pregnancy in a patient with rheumatic heart disease with bronchopneumonia. Another factor of preventability was a seven months pregnancy in an obese patient who had had previous cardiac surgery. The Committee felt that the death was preventable in that either the patient was responsible for traveling between hospitals while seriously ill or that no physician in any of the hospitals visited, assumed the responsibility for the total care of this patient. It was not stated that the patient contacted her obstetrician who, after all, was directly responsible for her prenatal care. It seems that the pregnancy in an obese cardiac patient with a severe bronchopneumonia was a combination of complications the therapy could not overcome.

Case No. 348—SEPTICEMIA FOLLOWING A CESAREAN SECTION FOR A BROW PRESENTATION COMPLICATED BY SEVERE PREECLAMPSIA.

A black married female, age 35, a Gravida I Para O, was admitted in early first stage labor, 38 weeks in her first pregnancy with the signs and symptoms of severe preeclampsia and weighing 160 1/2 pounds upon admission. The prenatal course was satisfactory with a weight gain of only 13 3/4 pounds and normal limits to her hematology, urinalysis and blood pressure. However, in the past two weeks she developed edema, tachycardia and hypertension. Upon admission the blood pressure was 170/110; pulse 134; temperature 99.2 degrees F. and respirations 26, hemoglobin 12.4; hmct. 38, WBC-16,500 with Segs 80, lymph-20, urinalysis normal.

Therapy was directed toward the control of the preeclampsia while labor continued. Upon admission the presenting part was at station minus two, with membranes intact and dilitation only a fingertip.

On December 24th she was admitted and followed in early first stage labor. On December 25th,

she received at 1:00 A. M. Mag. Sulfate 10 gm. I.M.; at 9:00 A. M. Mag. Sulfate 5 gm. I. M. and at 2:30 P. M. and 7:00 P. M. she received Levaprone amp. I. At that time the cervix was dilated 6 cm. with the station at minus two. Temperature 100 degrees F.; Pulse 130 and blood pressure 154/84. The membranes ruptured and she passed a foul smelling meconium stained amniotic fluid.

On December 26, 1970,, x-ray examination reveals there is an adequate pelvis but there is a persistent brow presentation. The cervix is still dilated 6 cm. with no further progress in the past 12-14 hours. Effacement still 50 per cent and the presenting part is at station minus two. Consultation with a general surgeon produced an agreement to perform a section and this was done. At section; the hemoglobin was 12.4, Hmct. 38; WBC 16,500; Segs 80, lymph 20; urinalysis normal. At surgery they delivered a viable female fetus which survives. They discovered several large intramural fibroids and several smaller submucous fibroids. There were several adhesions about the tubes and ovaries but the operation was without incident. Her weight at time of surgery was 160 1/2 pounds. From December 27, 1970 until her death on January 18, 1971, she developed a paralytic ileus and an elevation of temperature. Both complications were treated but they never returned to normal. On January 4, she had several liquid bowel movements and the abdominal distention returned. On January 8, the incision drained with a foul smelling discharge. On January 14 she was taken to surgery where the slough was excised from the incision and a pelvic abscess drained. On January 17 she was too debilitated to drain the pelvic abscess from below, so a forceps was introduced into the lower part of the abdominal incision and a large amount of bloody, purulent, foul-smelling material was drained.

On January 18, 1971, her blood pressure dropped to 60/0, pulse 140, respirations 40 and she became lethargic and stopped breathing. This was 35 days after her admission. There was no autopsy.

Comment: The direct obstetric cause of death was septicemia but this was a result of the long labor, the preeclampsia and the fact that she was an elderly primigravida, not in good physical condition. There was a 48-hour delay between the time she started into labor, and when the section was performed. During the first 24 hours she dilated to 6 cm. with the station of the head at minus two. Twenty-four hours later she had the same dilitation of the cervix and no further advancement of the presenting part into the pelvis. An x-ray was taken and a persistent brow presentation was discovered. It was here that the physician failed to appreciate the complication, but even if the complication did not exist, the lack of progress should have alerted the physicians to consider a cesarean section in the first six to twelve hours of active labor. Repeated examinations, the premature rupture of the membranes, the debility due to the preeclampsia and the 48-hour labor all contributed to the paralytic ileus following the section. It was here that the contaminants entered the blood stream to produce the septicemia, from which she could not recover.

Case No. 350—MULTIPLE CONTUSIONS AND INJURIES FROM A FALL IN AN EPILEPTIC TYPE OF INDIVIDUAL WHO WAS SIX MONTHS PREGNANT.

A white married female, age 17, a gravida 1 para 0 was admitted to an out-of-state hospital with the history of being six months pregnant and falling in a bathtub. She was unconscious upon admission and in status epilepticus. She was treated for the status epilepticus and for possible eclampsia, after which the fetus was stillborn. She remained unresponsive and unconscious. The blood pressure during her seizures was monitored at 250 mm. of mercury and thereafter dropped to 180 and finally settled at 105-120/60-70.

Because of the lack of improvement from the unconscious state she was admitted to a university medical center for diagnosis and treatment. In addition to the multiple contusions about the face and neck, she had contusions on the flank and along the back and the back of the legs. Neurological examination revealed a deeply comatose female and in the motor area only reflex decerebrate posturing on painful stimulation. The cranial nerves were non-reactive — pupils were nonreactive, the right was larger than the left: 5 mm on the right and 3.5 mm. on the left. No extravascular movements were present. There was an absence of doll's eyes movements. Coordination could not be tested. Fundoscopic examination revealed bilateral blurring of the nasal disc margins.

The course in the hospital centered around the tests performed for diagnosis. Upon admission, a right retrobrachial arteriogram was performed and was normal. On the second hospital day a right frontal ventriculostomy was performed and a ventriculogram to rule out the possibilities of an acute hydrocephalus but these tests were normal. The patient remained unchanged (in the coma) for the next seven days, when she had a respiratory arrest. She was maintained on a mechanical respirator for another day and then was pronounced dead. There was no autopsy.

Comment: Direct obstetric cause of death was multiple contusions and injuries. The major injury was thought to be a brain stem contusion. There were no factors of preventability or responsibility recognized by the Committee.

*Case No. 351—CEREBRAL VASCULAR ACCI*DENT IN A MULTIPARA WITH A HISTORY OF TWO PREVIOUS CEREBRAL VASCULAR ACCIDENTS.

A white, female, age 43, a Gravida 7 para 6,

was 7 1/2 months in her seventh pregancy when she fell getting out of her car and became unconscious. The patient had a history of two previous cerebral vascular accidents. The two incidents happened between 1967 and December of 1969 when she had her second cerebral vascular accident. She had a history of hypertension with a blood pressure of 160/100 as an average and a weight problem of weighing 254 pounds more or less, depending on her diet and ability to lose weight.

Her first examination in 1967 showed arteriosclerotic changes in the fundi. The present pregnancy started in April and she was due in January. With the present admission the patient was unconscious, the blood pressure ranged from 140/90 to 160/100, and after neurological examination she was found to have a right hemiplegia. She also had convulsions and clonus in the right extremity. She was first treated with glucose 10 per cent in H_2O, Lasix and Serpasil. Penicillin was added to the intravenous fluids. The convulsions were treated with Sodium Luminal 1 c. c. I. M. On the second hospital day there was no improvement from the unconscious state, so a cesarean section was performed without anesthesia, with the delivery of a premature stillborn male fetus. Following section she received Cedilanid, Largon, Atropine, and multiple doses of Mag. Sulfate. She continued in the unconscious state with no improvement, in spite of heroic measures to control the cerebral hemorrhage, but every effort was met with failure. On the third day after admission, she finally expired. There was no autopsy.

Comment: The direct obstetric cause of death was pregnancy in an elderly multigravida who had permanent hypertensive vascular disease, and a history of two previous cerebral vascular accidents. The patient was extremely obese weighing 254 pounds in a non-pregnant state. The Committee was unanimous in the opnion that this patient should have been sterilized after four pregnancies, and when the present pregnancy was diagnosed she should have been aborted, no matter the gestational age of the pregnancy. To permit her to continue in the pregnancy with this tragic background of hypertension, obesity and two previous cerebral vascular accidents, was to condemn her to certain permanent complications incident with stroke or certain death.

CASE No. 353—CONGENITAL COARCTATION OF THE AORTA AND RHEUMATIC HEART DISEASE COMPLICATED BY PREGNANCY.

A white, married female, age 23. about 2-3 months in her first pregnancy was admitted with severe edema, cyanosis and some rales in the lung fields bilaterally. The patient had a congenital coarctation of the aorta and rheumatic heart disease, which had been partially repaired by cardiac surgery. The patient had been warned never to become pregnant but she was approximately 2-3 months when the pregnancy was discovered and the cardiac complications became severe. She had been under the care of a general practitioner for many years and since becoming pregnant had gained 30 pounds. She was under treatment by another physician who prescribed Lasix 40 mg. daily.

In addition to the above symptoms, an x-ray demonstrated cardiac enlargement but the lungs fields were clear. The E.K.G. revealed a sinus tachycardia, right axis deviation; R. V. D. with strain. Prominent P waves. The tracing suggested cor pulmonale or congenital heart disease.

The patient was admitted to the hospital in poor physical condition with severe edema, cyanosis and rales in the lung fields. For the next 10 days an attempt was more to stabilize her failing heart. She was digitalized, placed on bed rest and put on a low salt diet. She received oxygen PRN, Trilifon gm. 2 Q. I. D.; Macrodantin mg. 100 Q. I. D. with food; and on the seventh hospital day was placed on penicillin 600,000 Units B. I. D. She was followed with daily W. B. C. and hemoglobin determinations. She had a venoclysis on the fourth and sixth day and on the day of her death her WBC was 16,450 and the Hgb. 16.0 grams per cent. Her condition improved and she remained afebrile, but she died suddenly and without the help of an autopsy the complication causing her death was diagnosed as a massive cerebral hemorrhage or a massive pulmonary embolus. She remained undelivered.

Case No. 354—SEPTIC ABORTION RELATED TO EXTERNAL TRAUMA (FALLING ASTRADDLE OF A BATHTUB) WITH A POSSIBILITY OF A SELF-INDUCED OR A CRIMINAL ABORTION.

A white married female, age 31, was admitted to the hospital with a temperature of 101 degrees F.; in acute distress with violent lower abdominal pain, and in shock with sweating and a very pale facies. The evening prior to admission she was getting out of a tub when her foot slipped and she fell, landing astraddle the side of the tub. She is quite obese and struck rather hard but did not have any particular pain afterward. She was approximately 3 1/2 months in her fourth pregnancy and she was a Gravida 4 Para 2, Abortus 1 (10 years ago).

Her past history was negative and she was in good general health until her fall, except for endogenous obesity. On the morning of her admission she got her husband off to work at 5:00 A. M., then she developed fever. lower abdominal pain, vomiting and vaginal bleeding. The pain increased until hospital admission was indicated. The physical examination was not remarkable except for the pelvic which revealed the uterus to be enlarged to the size of a three months

pregnancy and retroverted. The cervix was soft but not dilated more than a finger tip. There was some old blood in the cul-de-sac with some odor. The admission diagnosis was inevitable abortion (question of septic abortion), or a possible volvulus or perforated diverticulum.

Four hours after admission she passed a foul smelling necrotic fetus about four months gestation but the placenta was not complete. She had a D and C using a ring forceps then a sharp curette and had one pack in the uterus. Three hours later her blood pressure kept dropping slowly and she was going downhill so rapidly that an emergency laparotomy was performed with the following findings. The pathology was confined to the uterus which appeared to be about three months gestation in size. It was boggy, edematous and a purplish color. The left ovary was dark purple and almost completely black and the right ovary was a slight lighter color than the other. There was from 60 to 100 c. c. of bloody pus in the dul-de-sac and lower abdomen. She had two cardiac arrests, the second of which was fatal. There was no autopsy. Because of the overwhelming infection of the uterus, gangrene of the ovaries, and the products of pregnancy, the diagnosis of a self-induced or criminal abortion was entertained but in the absence of an autopsy, it was not proven.

Case No. 355—AFIBRINOGENEMIA DEVELOPING AT THE TIME OF CESAREAN SECTION. DEAD FETUS SYNDROME.

A white married female, age 35, a Gravida 4 Para 2, stillbirth 1, was admitted with a fever of 104 degrees F; and a severe urinary tract infection. She was full term in her fourth pregnancy, not in labor and with a dead fetus. The admission examination was negative. The hematology showed 13.5 grams of hemoglobin with a WBC of 17,800. Urinalysis was negative for albumin, sugar and microscopic but positive for bile. An x-ray revealed a single pregnancy with a breech presentation. Four hours after hospital admission the patient went into active labor but after four hours of labor there was no progress made. Preparations were made for a cesarean section and this was carried out immediately. A nonviable macerated and decomposed fetus was delivered after an hour of halothane anesthesia. Immediately after section the patient began to bleed profusely from the vagina, the abdominal incision and from the venopuncture wounds. She received two units of fibrinogen; eleven units of whole blood; 4,000 c. c. of saline; 1,000 c. c. glucose; dextran 1,500 c. c.; and mannitol 1,000 c. c. Urinary output was zero. She was in severe shock and expired five hours after delivery. There was no autopsy. The Committee reasoned that the patient was overtreated with fluids and undertreated with fibrinogen.

Case No. 357 — UPPER RESPIRATORY INFECTION IN A SIX MONTHS PREGNANCY, WITH DELIVERY, RETAINED PLACENTA, BACTEREMIA, SEPTICEMIA AND PERITONITIS.

A white married female, age 17, a Gravida 1, Para 0, was admitted in active labor in poor physical condition because of a severe upper respiratory infection. During her prenatal visits she had been treated for a urinary tract infection, a trichomonas vaginitis and otitis media. She was seen the day before hospital admission with a severe upper respiratory infection for which Bicillin 2 c. c. was given. The patient was ready for delivery upon admission and she had a severe vaginal hemorrhage just before delivery. Her admission examination revealed a pulse of 120; blood pressure 80/40; and the patient pale and in shock. She was six months in her first pregnancy. She delivered a viable premature male infant weighing 1 pound and 8 ounces which expired. The severe bleeding continued after delivery and with the retained placenta an emergency D and C was performed and the placenta removed. The patient ran a high temperature and was started on Ampicillan 500 mg. q. i. d.

During the next 19 days the patient developed bacteremia, septicemia and peritonitis. Heroic measures were undertaken using whole blood, intravenous fluids, multiple schedules of antibiotics and correction of the body chemistry, but in spite of this extensive schedule of therapy, the patient expired and there was no autopsy. The Committee agreed that there were no factors of preventability or factors of responsibility involved in this maternal death.

Case No. 358—AMNIOTIC FLUID EMBOLISM IMMEDIATELY POSTPARTUM.

A white married female, age 29, a Gravida 5 Para 3, was admitted to the hospital in active labor and in good physical condition. She had adequate prenatal care, a weight gain of 36 pounds with normal ranges of her hematology and urinalysis. She was admitted in active labor with intense and violent contractions. The membranes were ruptured manually 30 minutes before delivery. She received Demerol mg. 50 and Scopolamine gr 1/150 intravenously 35 minutes before delivery, and was delivered with a saddle block anesthetic. She was in first stage labor only 2 1/2 hours. She delivered a viable fetus weighing seven pounds and six ounces, over a median episiotomy and was resuscitated immediately with an Apgar of nine. The patient received Methergine 1 c. c. IV immediately after the placenta was delivered.

During the episiotomy repair the patient developed breathing difficulty and went into profound cardiovascular and respiratory collapse. She was immediately intubated and given positive

pressure oxygen, vasopressors and external cardiac massage. A defibrillator was applied with a sinus rhythm noted. During the next three hours the blood pressure fluctuated between 104/72, to no blood pressure, then with Aramine it rose to 150/130. Spontaneous respirations returned, then in a short time she stopped breathing and the blood pressure was lost again. Respirations were assisted and she developed a sinus bradycardia, then junctional bradycardia, and idioventricular rhythm, widening of the QRS complexes, rate approximately 40 per minute and finally ventricular fibrillation. She developed afibrinogenemia with 500 c. c. of unclotted blood found in the bed. She expired three hours following delivery. There was an autopsy with the cause of death—amniotic fluid embolism.

Case No. 359—UNATTENDED ABORTION.

The postmortem data on this maternal death follows: She was a 32-year-old, not married, black female, found dead in bed. The coroner supplied the information that she was five feet, eight inches in height, and weighed 145 pounds; that she was pregnant and apparently had hemorrhaged to death from an abortion. She was an alcoholic and apparently intoxicated at the time of her death. The coroner reasoned that she had been unattended medically for 36 hours prior to her death. There was no autopsy and no identity to the person responsible for the abortion.

Case No. 360—CARDIAC ARRHYTHMIA WITH A HISTORY OF PAROXYSMAL ATRIAL TACHYCARDIA.

A white, married female, age 39, a Gravida 3 Para 2 was admitted in active labor. She was in good physical condition, having 11 prenatal office visits with normal progress during the prenatal period. Her physical standards were within normal limits, the weight gain was 14 pounds, hematology and urinalysis findings were within normal limits. Her first pregnancy delivered in 1968 with no complications noted. During the second pregnancy, tachycardia was noted prenatally, and the patient was treated by an internist with numerous medications for paroxysmal atrial tachycardia. Several cardiologists reviewed her records at that time, but treatment was of little use. She delivered at term in 1970 and had no problems. With the present pregnancy, the patient was advised to consult with her cardiologist and internist during the prenatal period but there is no evidence that this was done. After an eight hour labor, the patient delivered a seven pound fetus under saddle block anesthesia. The postpartum course was normal with normal voiding, bowel function and eating. In the early morning of the third postpartum day the patient began to breathe in a peculiar manner and the nurse found her in cardio-respiratory collapse. In spite of resuscitative efforts the patient expired. There was an autopsy.

The final anatomic diagnosis was: (1) Pulmonary congestion and edema; (2) Passive congestion of the liver and spleen; (3) Dilatation of right atrium and ventricle moderate; (4) Enlarged postpartum uterus (2 days); and (5) Acute tracheobronchitis. Cause of death: probable cardiac arrhythmia because of the past clinical history of paroxysmal atrial tachycardia.

Case No. 361—BILATERAL BRONCHOPNEUMONIA IN A FOUR AND A HALF MONTHS PREGNANCY.

A white, married female, age 34, a Gravida 3 Para 2, was admitted with shortness of breath and cyanosis following an episode of influenza. She was admitted with the diagnosis of bilateral bronchopneumonia. She had four prenatal office visits and had made normal progress. The two previous deliveries were normal and the children survive. Upon admission she became very short of breath, associated with cyanosis of the extremities and had difficulty in breathing. The admission temperature was 100.8°F, pulse 110, respirations 60 and a blood pressure of 210/80. The admission examination revealed an inflamed throat, consolidation and rales in both lungs. The abdomen and fundus were normal for a four and half months pregnancy. She received antibiotics, oxygen, alevaire and supportive therapy, but she had a gradual downhill course. On the second morning she had several episodes of cardia standstill and stopped breathing; this continued for 45 minutes when she finally expired. There was no autopsy.

Case No. 362—SEVERE VIRAL PNEUMONIA IN A FIVE AND A HALF MONTHS PREGNANCY.

A white, 28-year-old female, a Gravida 1, Para 0, was found dead in bed following an upper respiratory infection. She was five months in her first pregnancy and this was at the height of an influenza epidemic in this area. This patient had been a moderate schizophrenic for five to seven months with multiple complaints and frequent surgery. She had several D and C's for menstrual difficulties and a cholecystectomy in December 1971. She had rheumatic fever as a child, resulting in rheumatic heart disease. Just prior to her death, an upper respiratory infection was treated by her family physician as a pneumonitis and marked depression, using Lincocin and Elavil. The following day she called her husband stating that she was not improving and an hour later he found her dead in bed with foam exuding from the nose. There was an autopsy.

The autopsy findings were: (1) Viral pneumonia, bilateral, severe, with superimposed bacterial pneumonia; (2) Acute tracheobronchitis, severe, (3) Pleural effusions (150 cc); (4) Passive congestion of viscera, moderate, and (5) Intrauterine pregnancy, male fetus which measures 25 cm. crown heel length.

Case No. 363—AMNIOTIC FLUID EMBOLISM DUE TO FETAL DEATH IN UTERO.

A white, married female, age 33, a Gravida 5, Para 4, was admitted to the hospital with considerable back pain, the result of fainting and falling at home, injuring the lumbo-sacral spine. The patient was eight and one-half months in her fifth pregnancy and her condition upon hospital admission, was considered good. She had eight prenatal office visits in four months with normal limits in serum electrolytes, a mild secondary anemia and normal urinalysis. The patient was admitted with a blood pressure of 110/70 and a pulse of 80. Physical findings were normal for an eight and one-half months pregnancy and the nurse heard fetal heart tones in the left lower quadrant. Examination revealed pain in the lumbosacral spine and right hip radiating down the leg. She was unable to rotate externally without difficulty or to raise the extremity without pain. As the day progressed the blood pressure fell from 124/68 to 90/60, pulse 130, and she began vomiting. Oxygen, glucose 5/W 1000 c.c., I. V.; and Solu-Medrol were administered. The uterus was soft and irregular with no contractions. The fetal heart tones were not heard and it was reasoned that the nurse was counting the maternal abdominal pulse instead of the fetal heart tones. The patient continued in shock with a severe hypotension, tachycardia, skin cold and clammy, and perspiring freely. At 3:00 A.M. the patient went into active labor but the shock state continued with an average blood pressure of 60/40 to 70/64, and a pulse of 120. Labor progressed and the shock state continued with restlessness, ashen color, blood pressure of 70/40 and a pulse of 120. Six and a half hours later she delivered a stillborn fetus by frank breech with oxygen only and no anesthesia. The fetus was macerated and estimated to be dead at least two days. The placenta was delivered intact and complete with no signs of premature separation or abruptio placentae. She received Syntocinon and Methergine. The condition of the patient deteriorated rapidly, in spite of continued intravenous medications and Solu-Medrol. The pulse and respirations ceased. Two obstetricians were standing by in the last stages and one drew blood for a laboratory procedure and it was noted that the blood did not clot. There was no autopsy. This was 22-1/2 hours after admission. The Committee commented that in the absence of an autopsy the clinical diagnosis was amniotic fluid embolism, due to the changes caused by the stillborn fetus in utero.

Case No. 365—PERFORATION OF THE RIGHT INNOMINATE ARTERY WITH HEMORRHAGE INTO THE TRACHEO-BRONCHIAL TREE COMPLICATING A TRACHEOSTOMY FOR CARDIO-RESPIRATORY ARREST.

A black, married female, age 18, was admitted to the hospital for an elective cesarean section for Hemoglobin Sickle Cell disease. The patient had several episodes of hemolytic crises in the past and a cesarean section would prevent a crisis because of the stress of a long labor. She had adequate prenatal care with a mild anemia and hematuria. Labor began at home and the cervix was long, thick and closed on admission. The cesarean section was started the following day with the delivery of a viable fetus weighing eight pounds and two ounces, which survives. With the delivery of the placenta, the patient developed respiratory arrest, then ventricular fibrillation. She was defibrillated, had a tracheostomy and admitted to ICU where she was on a respirator. She was continually unconscious and supported by respirator for the next eight days when she started profuse bleeding from the tracheostomy opening, then expired. There was an autopsy.

Anatomical Diagnosis: (1) Recent post-operative status—(a) cesarean section, complicated by cardio-respiratory arrest (clinical) and: (b) tracheostomy complicated by erosion into the right innominate artery with perforation and hemorrhage into tracheo-bronchial tree; (2) Multiple pulmonary emboli, left lung with multiple pulmonary infarcts; (3) Infarcts of the spleen small, (4) Focal necrosis with acute and chronic inflammation of the liver, and (5) Hemoglobin S.C. Disease (clinical).

Case No. 371—CARDIAC ARREST AT THREE WEEKS POSTPARTUM—POSSIBLE ELECTROCUTION.

A white, married female, age 31, Gravida 1, Para 1, was admitted D.O.A., having delivered a normal female fetus three weeks before her death. She was sewing one evening during an electrical storm and continued to work after the family had retired to bed. They found her the next morning lying on the floor with the sewing machine light still on. She was removed to the hospital for an autopsy. The mother-in-law stated that she saw the deceased person alive about midnight and she was complaining of a severe headache. About four hours later she was found dead. She had a normal prenatal course, normal eight-hour labor and uneventful delivery, normal three-day hospital stay and a normal postpartum state at home until her death.

The autopsy revealed marked congestion and cyanosis of all viscera. Cyanosis of the skin over head, face and neck. Microscopic findings: revealed pulmonary alveolar edema, "irritation" liver. Focal interstitial hemorrhage with hypoxic degeneration of myocardium of the left ventricle. Focal degeneration with lymphocytic infiltration of posterior lobe of the pituitary gland.

Comment: Death is attributed to cardiac arrest. Focal evidence of hypoxia with microscopic hemorrhage and myocardial degeneration is seen in the left ventricle.

Medical Grand Rounds

From the West Virginia University
Medical Center
Edited By
Raymond B. Weiss, M. D.
Assistant Professor of Medicine

Medical Aspects of Bone Malignancies

Raymond B. Weiss, M.D.

Bone cancers are rare tumors, but they occur primarily in young individuals and the cure rate for most of them in the past has been low. If the over-all survival and cure rates for these malignancies can be improved, the extra duration of life can be very meaningful in the young patient.

These tumors present to the physician most commonly as a problem of persistent pain. As part of standard evaluation of this symptom, an x-ray is taken and an abnormality is noted. Since histology is the definitive diagnosis of malignancy, a biopsy is done. If the lesion is located in an extremity, then the primary, and frequently only, modality of therapy has been amputation. As the field of oncology has developed and more effective therapies have been devised, the management of bone cancers has become more of a multi-disciplinary field involving surgery, radiation therapy, and more recently chemotherapy. The addition of radiation and chemotherapy to surgical treatment has in some cases improved cure rates and in others offered increased survival when palliating metastatic disease.

Ewing's sarcoma and osteosarcoma will be discussed in detail showing how radiation and/or chemotherapy in addition to surgery can be of value in their management. Some basic science aspects of the etiology of osteosarcoma and the use of the new chemotherapeutic agent, adriamycin, will also be discussed.

Ewing's Sarcoma

Ewing's sarcoma was first described in 1921 by James Ewing, a New York City pathologist who was probably the first physician to limit his scope of interest to cancer.[1] He pointed out how this small round cell tumor was a distinct pathologic entity occurring primarily in young people and how it was being mistakenly categorized as an osteosarcoma. Being the compleat oncologist that he was, he was also the first to demonstrate that this tumor responded to irradiation, using radium as the radiation source.

It is a rare tumor as only eight cases have been recorded in the WVU Medical Center Tumor Registry in as many years. Ninety five per cent of the patients with this tumor are in the age range of 5-25 years, and it is rarely ever seen much beyond age 25. There is a 2:1 male: female ratio, and most all patients are Caucasian as it rarely occurs in Negroes.

Almost any bone can be involved primarily with the most frequent sites being the shafts of the humerus, femur, or tibia and the pelvic bones. The tumor mass can spread extra-osseously, and pathologic exam on amputated specimens has demonstrated that even though the tumor appears to be localized to one area of a bone clinically, it usually involves the entire bone.

Case Presentation

The patient is a 22-year-old man who developed persistent pain in his right groin about eight months prior to admission. He saw a physician who did an x-ray. It showed a lytic area in the right pubic bone and a biopsy was recommended. However the patient delayed biopsy until one month prior to admission when a firm mass became palpable in the groin. Biopsy was then done and the lesion was diagnosed as Ewing's sarcoma.

Upon referral to WVU Hospital x-rays showed a lytic lesion in the pubis and acetabulum with an extra-osseus mass displacing the bladder on IVP (Figures 1 and 2). Chest film, bone scan and marrow biopsies were negative for metastases. The serum LDH was 350 (normal 100-225).

Figures 1 and 2. AP view of the pelvis and an IVP of the patient with Ewing's sarcoma. Note the lytic areas in the right pubis (arrows) and the extra-osseus mass which displaces the bladder.

Cobalt therapy was begun to the pelvis and cyclophosphamide (Cytoxan) and vincristine were given concurrently, although the Cytoxan was not given in full scheduled dose because of leucopenia. Dactinomycin was begun as soon as the cobalt therapy was completed.

The patient did well for about five months when he developed rib and scalp metastases. He had temporary remissions from methotrexate and adriamycin, but subsequently died with diffuse metastases in every organ.

Discussion

Local pain and swelling are the most frequent presenting symptoms. Many patients also have a fever, leucocytosis, increased sedimentation rate, and some are anemic. In one series of 21 patients,[2] fever greater than 100° uniformly was associated with a fatal prognosis. The serum lactic dehydrogenase (LDH) is frequently elevated, presumably because of the growth and destruction of the tumor cells which are producing this enzyme.

Ewing's sarcoma has many similarities to lymphoma — its pathology, its responsiveness to radiation and certain chemotherapeutic agents, and in these associated systemic signs and symptoms. As in lymphomas, patients with systemic symptoms such as fever frequently have disseminated disease and a poor prognosis.

The malignancy metastasizes primarly to the lung and other bones. Autopsy studies have particularly emphasized the spread to other bones but there is an unanswerable question here, is this widespread metastases or is it multicentric origin? This involvement of other bones can sometimes be detected early by bone marrow examination.

In a large cumulative review of the literature[3] the over-all five-year survival was only 8 per cent. Even some of those patients who live five years still eventually die of their disease, so life-time cures are rarities. In a series of patients reported from Walter Reed Army Hospital[4] over half the patients were dead in the first year of follow-up after treatment and 75 per cent had died by two years. So it is very apparent that this is a rapidly fatal tumor in the majority of cases.

As was previously mentioned, Ewing found that this tumor was radio-sensitive. Amputation has also been used as primary therapy if the tumor was located in an extremity When one looks at the group of patients with no apparent metastases at the time of diagnosis, both amputation and large dose radiation are effective in controlling the primary lesion. If at least 3000 r of radiation is given only rarely does the patient have a relapse of tumor in the primary site. [4, 5, 6] The best five-year survival rate reported with this tumor was 30 per cent and was in a series[5] in which radiation was used as primary therapy. So since there is no difference in the five-year survival data between radiation and amputation, it is generally recommended that this tumor be treated primarily with radiation to spare the patient the mutilation of amputation. The entire involved bone must be treated to be sure all primary tumor is eradicated.

The failure to have a better five-year survival

rate is not due to lack of control of the primary lesion, but to early subclinical metastases that later become obvious, most often within one year after primary treatment. As was previously mentioned, the large majority of patients have died of these metastases by two years. This sort of situation makes this tumor a potential candidate for improving survival and preventing tumor relapse by utilizing systemic therapy in addition to treating the primary lesion.

When there is known metastatic tumor, the patient is usually only a palliative treatment candidate, although occasional long survivals have been effected by irradiating or resecting single lung metastases. Five drugs have been demonstrated to have an effect in causing regression of metastatic Ewing's sarcoma with an increase in survival. They are cyclophosphamide (Cytoxan), vincristine (Oncovin), dactinomycin (Cosmegen), 5 - fluorouracil, and BCNU. Each of these drugs has a different mechanism of action and different toxicity, so they could be expected to be more effective when used in combination rather than individually. Based on this knowledge it was postulated that using a combination of drugs plus radiation to the primary lesion would result in good control of the primary tumor while preventing growth of subclinical metastases resulting in better overall survival. Protocols were devised using a combination of large dose radiation (at least 5000 r) for total obliteration of the primary disease while giving concurrent cyclophosphamide and vincristine. Radiation and dactinomycin have synergistic skin toxicity so this drug was added to the combination regimen after the irradiation was completed.

The largest series reported[7] using this curative-attempt approach is from St. Jude's Children's Hospital in Memphis. Of 15 newly-diagnosed patients treated with radiation — cyclophosphamide — vincristine combination, eight were reported as being continuously free of disease with a minimum of 12 months and a maximum of 91 months follow-up. Johnson et al[8] at the National Cancer Institute reported 7 of 13 patients being free of recurrence with a minimum of six months follow-up. Based on these promising early trials a nationwide study has been launched to test the hypothesis that radiation therapy given to the primary tumor and adjunctive chemotherapy given for two years will result in greater numbers of permanent cures. The Acute Leukemia Group B (ALGB) of which WVU Hospital is a member is participating in this clinical trial. Since the majority of metastases occur in the lung, prophylactic irradiation of the whole lungs will be utilized in some patients in addition to the drugs to see if this treatment can further prevent metastatic tumor occurrence.

There is precedent that this aggressive multimodality therapeutic approach will accomplish its goal. For example, the five-year survival in Wilm's tumor and childhood acute lymphoblastic leukemia have been markedly improved in recent years by the same approach.

Osteosarcoma

Osteogenic sarcoma is the most common primary bone cancer. The peak incidence occurs in the age range of 10-25 years, so again it affects young people. There is well-documented occurrence of osteosarcoma in bones affected by long-standing Paget's disease and in bones which previously have been subjected to high doses of radiation therapy. These two predisposing factors account for many of the osteosarcomas seen in older age groups. The most frequent site of origin is in long bones and the femur accounts for over half the primary sites of tumor. There are no significant changes in the serum calcium or phosphorus levels, but the alkaline phosphatase which reflects new bone formation is usually significantly elevated.[2]

Case Presentation

The patient is a 15-year-old boy who first had trouble with his left knee two months prior to admission when he fell while playing basketball. The knee became stiff and painful and he saw his local physician who advised rest and use of crutches. After two weeks the knee was more swollen and an arthrocentesis was performed. The procedure provided no improvement so he was referred to an orthopedist who removed more fluid and prescribed ice packs. Six weeks after the initial injury an x-ray was done (Figures 3 and 4) which showed changes in the distal femur compatible with malignancy. An open biopsy was peformed and the interpretation was osteogenic sarcoma.

Four days after the biopsy he had a sudden, spontaneous pneumothorax on the left, and a chest tube was inserted. A small amount of pleural fluid was aspirated by the suction tube and cell blocks of this material revealed metastatic osteogenic sarcoma. There had been no previous chest x-ray evidence of metastases. A skeletal survey revealed no other bony lesions. He was then referred to WVU for therapeutic management.

Since he already had pulmonary metastases, no leg amputation was done. The pneumothorax

Figures 3 and 4. AP and lateral views of the distal femur of the patient with osteogenic sarcoma. The distal femur is the most common primary site of this tumor, and the new bone formation (arrows) with periosteal reaction in a young patient make the diagnosis of osteosarcoma almost a certainty.

responded to instillation of nitrogen mustard and suction drainage. He was begun on cobalt therapy to his leg and intravenous adriamycin chemotherapy. One abnormal lab test was a serum alkaline phosphatase of 372 (normal 30-80); the calcium was normal.

Discussion

The etiology of osteosarcoma has been investigated in some detail. It is a frequent complaint of the patient that he sustained some sort of minor trauma and then pain and swelling (the most common presenting symptoms) began within a few weeks. It is difficult to really implicate trauma as a precipitating factor as thousands of people sustain major bony injuries and don't develop cancer.

There have been some isolated reports of several members of one family (usually siblings) developing osteosarcomas and/or chondrosarcomas. This occasional familial occurrence raises the question of either genetic or infectious etiologic factors, or what is more likely, both of these.

It has long been known that chicken and mouse osteosarcomas can be induced by viruses. Rous proved the viral etiology of chicken osteosarcoma back in 1912. If cell-free extracts of mouse osteosarcoma are injected into newborn mice, osteosarcoma will later develop in these mice. Pritchard et al[9] have repeatedly successfully induced osteosarcomas in hamsters by injecting cell-free extracts of human osteosarcoma tissue in the animals at birth. This tumor is rare in hamsters under natural conditions.

Tumors that are induced by a given animal oncogenic virus express a common cell surface antigen, the tumor-specific antigen. Morton et al[10] have demonstrated the presence of tumor-specific antibodies against osteosarcoma tissue from six different patients in 80 per cent of a series of other patients with the same tumor. Presumably most all osteosarcomas contain the same tumor-specific antigen (a virus or virus product?) which excites the production of similar antibodies.

These antibodies were cytotoxic to the tumor cells (meaning they inhibited growth in tissue culture), but were not toxic to normal fibroblasts. There was no reaction when serum from

the osteosarcoma patients was tested against a variety of other tumor types. Thus there is good evidence these antibodies are very specific for osteosarcoma cell antigens.

A further very interesting finding in Morton et al's study was that close associates and family members of these osteosarcoma patients also had cross-reacting antibodies to the tumor whereas only a few normal, randomly-selected blood donors did. This evidence suggests that an infectious agent is associated with this neoplasm, presumbably a virus, and that people can be exposed to it, develop antibodies to it, but not develop the malignancy.

So far the evidence for an infectious virus being the etiology of human osteosarcoma is all circumstantial, but it is evidence which is more and more incriminating. If animal osteosarcomas are induced by viruses as we know they are, there is no reason to feel that the human form is any different.

Getting back to the clinical aspects of this tumor, death is almost exclusively from lung metastases as the tumor rarely metastasizes to any other site. Spontaneous pneumothorax which occurred in our patient has been previously reported as being the first sign of metastases even before they can be seen on chest x-ray. It is postulated that a subpleural metastasis occurs, and the lesion undergoes necrosis thus producing an air-filled cyst that can break through the pleura and cause a pneumothorax.

Amputation in those patients who do not have obvious pulmonary metastases has been, and still is, the treatment of choice. These tumors are not very radiosensitive, as is Ewing's sarcoma, and thus control of the primary lesion is best accomplished surgically. However, again the five-year survival rate is low, varying from 10 to 23 per cent depending on the series reported.[11] Within a year of diagnosis, about half the patients have died of their disease.

For those patients with pulmonary metastases, chemotherapy has not been too successful. However, not much work has been done in this tumor as far as chemotherapy is concerned. Cytoxan, actinomycin D, low dose methotrexate, mitomycin C and a few others have been tested in patients with advanced disease, and the best objective tumor regression rates have been about 15 per cent. In a small series of patients,[12] very large doses (20-30 grams) of Methotrexate with toxicity reversal by the Methotrexate antidote, citrovorum factor, have resulted in some good tumor regressions and this therapy looks promising. Radiotherapy can be used for palliation, but high doses have to be given.

Sarcomas generally have not been very responsive to chemotherapy. But there is a new chemotherapeutic agent, adriamycin, which has been shown to have good anti-tumor effect in a variety of solid tumors of which sarcomas, both bone and soft tissue, are one prominent group. It is so effective in the sarcomas compared to any other single agent that I want to now cover some aspects of this drug and demonstrate how it will probably help increase the current rather low five-year survival for osteosarcoma.

Figure 5. The chest x-ray of the patient with poorly-differentiated sarcoma metastatic to the lungs. There are bilateral lesions (arrows). (Figure 6). Same patient one year later after adriamycin therapy. No tumor lesions are present. Radiation fibrosis is present in the left upper lobe.

Case Presentation

The patient is a 22-year-old man who first had stiffness and limitation of motion in his shoulder in 1968. Treatment for "arthritis" was given until a mass developed over the scapula extending into the axilla. In April 1972 he had a biopsy and this was interpreted as poorly-differentiated sarcoma. 6000 r of Co^{60} was administered to his shoulder. He later was treated with chlorambucil, dactinomycin, and vincristine for lung metastases. These drugs were ineffective and the lung lesions grew. In June 1973 he was referred to the WVU Hospital for further therapy. A chest x-ray at that time showed multiple lung metastases (Figure 5).

Adriamycin was started and was given at three-week intervals. He had toxicity in the form of nausea and vomiting, stomatitis, anorexia, and alopecia, but none of these problems required hospitalization. All therapy was given as an outpatient.

The lung lesions progressively decreased in size until by March 1974, they had entirely disappeared. His most recent film in May 1974 (Figure 6) continues to show no evidence of tumor, and there has been no recurrence in the shoulder. When the cumulative dose of 520 mg/m^2 was reached, the adriamycin was stopped. His complete remission is presently being mantained by intermittant high - dose methotrexate.

Discussion

Adriamycin is an antibiotic that was isolated in 1968 from a mutant strain of the fungus Streptomyces peucetius by the Farmitalia Company of Milan, Italy. It showed significant antitumor effect in animal models which has now been confirmed in human use. It has activity against a broad spectrum of solid tumors and also acute leukemia and lymphomas.[13] This drug will certainly achieve wide clinical use when it is released on the market in the near future.

Its toxicity is manifested by the usual problems with chemotherapeutic agents - marrow suppression, nausea and vomiting, alopecia and stomatitis. But it has a specific potentially life-threatening toxicity also, cardiomyopathy. In one series[14] of 719 patients who received less than a total dose of 550 mg/m^2, only one case of severe cardiomyopathy occurred. Of 41 patients in the same series who received more than 550 mg/m^2, there were 11 cases with eight deaths. These patients developed sudden, severe congestive heart failure one to six months after the last dose. It is now recommended that nobody receive more than 550 mg/m^2 total dose. The EKG will show ST-T wave changes, conduction abnormalities, and premature beats in many patients who have received less than 550 mg/m^2, but these are not associated with any serious clinical problems and are generally ignored.

Adriamycin has been used in a variety of sarcomas with a fairly consistent tumor response rate of 25 per cent. These responses are defined as at least 50 per cent regression in measurable tumor lesions. Looking at metastatic osteosarcoma specifically a 22 per cent response has been reported[13], but at Roswell Park Hospital in Buffalo 7 of 17 patients treated had good objective remissions.[15]

This initial experience with adriamycin was so encouraging that it was postulated that it could be used as an adjuvant treatment to amputation in osteosarcoma not yet shown to have metastases. As has previously been stated for Ewing's sarcoma, the low cure rate is not due to poor control of the primary tumor, but the early dissemination of subclinical metastases to the lung. If the drug is given when the number of cancer cells is small, it has a chance of totally obliterating all tumor and increasing the cure rate.

This hypothesis has been studied in a clinical trial by the Acute Leukemia Group B. Early results[15] show a definite decrease in the frequency of development of lung metastases when adriamycin is given for one year after amputation. Of 21 patients entered in the trial only five have relapsed with metastatic tumor and four of these did not have the full protocol-dictated dose of drug. Follow-up has been up to 24 months and approximately half of the patients should have relapsed by now.

High dose methotrexate with citrovorum factor has also been used in this surgical adjuvant situation, and it also has now been demonstrated to decrease the incidence of metastatic relapse[16]. Since there are still patients who do relapse with both drugs the next step in clinical trials is to use both adriamycin and methotrexate prophylactically.

Adriamycin has significant activity against Ewing's sarcoma when metastatic disease is present.[17] As progress is made in utilizing combination therapy in this disease, adriamycin will be included in the combinations.

It appears it can be said that both Ewing's sarcoma and osteosarcoma will be added to the list of malignancies in which the aggressive, multi-therapy approach will pay off in better survival and a higher number of permanent

cures. For the young people these tumors usually afflict, this is a distinctive accomplishment.

Summary

In summary I would like to emphasize some points.

1. Bone sarcomas usually affect the young age groups and are frequently very aggressive tumors that develop early, and almost always fatal, pulmonary metastases.

2. There is much circumstantial evidence to implicate an infectious agent as the etiology of sarcomas.

3. Ewing's sarcoma is a radiosensitive tumor and radiation can effectively obliterate all tumor in the primary site. To prevent the appearance of metastases, combination regimens of cyclophosphamide, vincristine, and actinomycin D are being utilized as adjuvants to the radiation therapy. Early studies indicate a much improved survival rate.

4. Osteosarcoma is not very radiosensitive and amputation has to be done. Surgical adjuvant therapy with adriamycin and/or methotrexate appears to be decreasing the frequency of metastases.

5. Two other bone sarcomas, fibrosarcoma and chondrosarcoma, are less aggressive tumors and are treated surgically. A significant number of these patients, however, still succumb to pulmonary metastases. Unfortunately chemotherapy seems to not be as efficacious in these slower growing tumors. Adriamycin has occasionally caused an objective remission but not with the frequency seen in other sarcomas. Hopefully new drugs and drug combinations will be found to be more active.

A list of references may be obtained by writing The Journal.

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Manuscripts to be presented for publication in *The West Virginia Medical Journal* should be typewritten, triple-spaced, on one side only of firm (not onion skin or flimsy), standard letter sized (8½ by 11 in.) white paper. Wide margins (at least 1¼ in. on left) should be left free of typing. On the first or title page should be shown the title of the article, the name (or names) of the author, and his degrees. Pages should be numbered consecutively, the page number being shown in the right upper corner along with the surname of the author.

Authors are requested to submit a carbon copy with the original or retain same in the event the manuscript is lost in transmittal.

Illustrations should be numbered and their approximate locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for cuts should be done in black (India) ink on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it. The author will bear the cost of all over two one-column halftone cuts.

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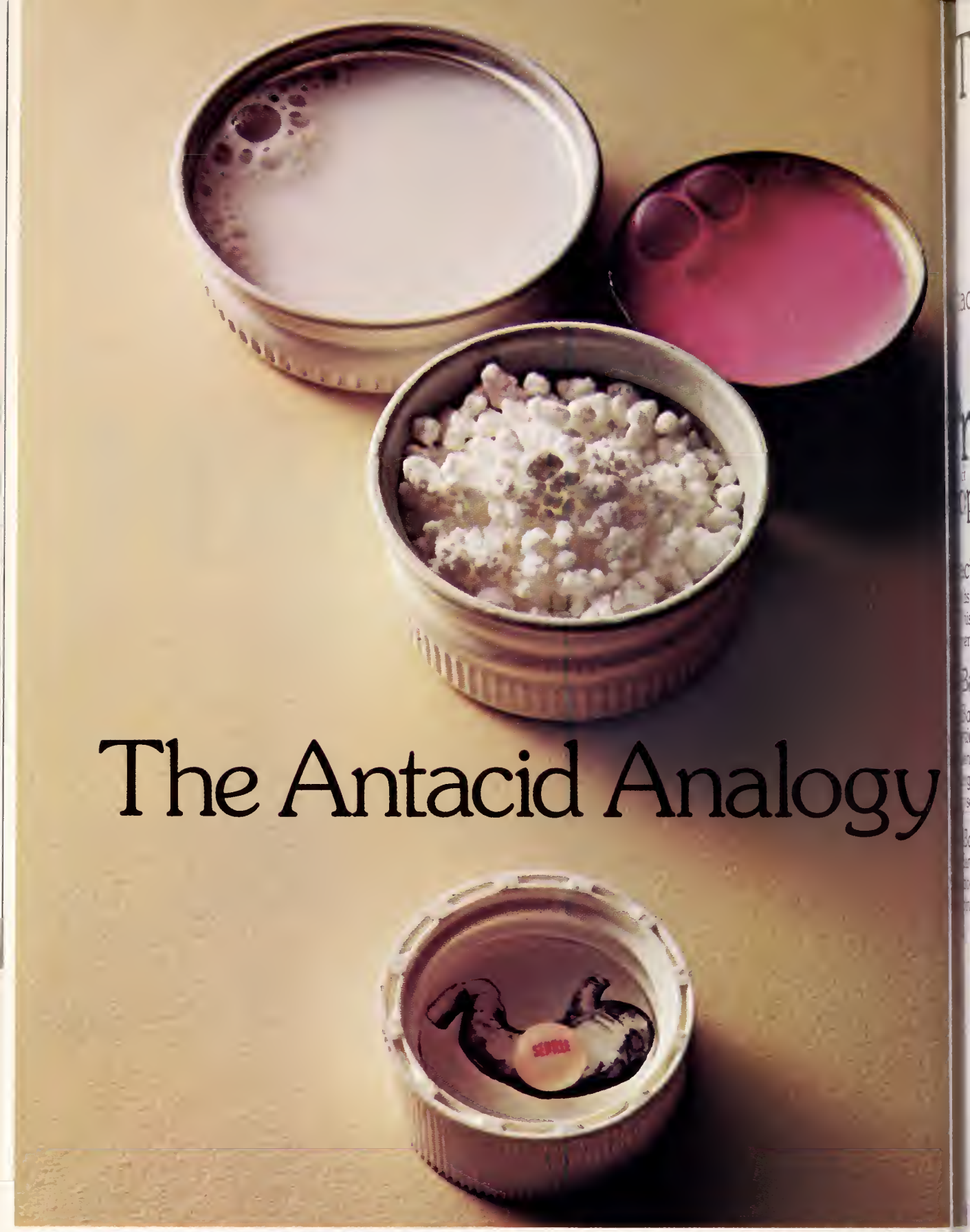

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*Innes, I. R., and Nickerson, M., in Goodman, L. S., and Gilman, A. (editors): The Pharmacological Basis of Therapeutics, ed. 4, New York, The Macmillan Company, 1970, p. 537.

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The Role of the Detail Man

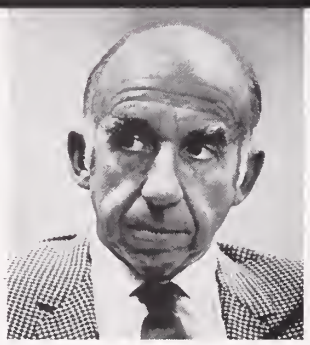
Opinion & Dialogue

Dr. Willard Gobbell
Family Physician
Encino, California

"I may be prejudiced, but I a very much in favor of the detail m I meet. Most of them are knowled able about the drugs they promot and can be a great help in acquai ing me with new medication."

Family Physician's Perception

I think that most general practitioners in this area feel as I do about the detail man. Over the years I have gotten to know most the men who visit me regularly ar they in turn have become aware c my particular interests and the n ture of my practice. They, therefore, limit their discussion as mu as possible to the areas of interes to me. Since I usually see the sam representative again in future visits, it is in his best interest to supply me with the most honest, factual, as well as up-to-date information about his products.



Dr. Jeremiah Stamler
Chairman
Department of Community Health and Preventive Medicine, and Dingman Professor of Cardiology
Northwestern University Medical School

"In the total picture of deali with health problems in this cour there is a potential for detail men to play a meaningful role."

The Positive Influence

My contact with representa tives and salesmen of the pharma ceutical industry is the type of co tact that people in a medical cent research people, and academic people have and that's in all likeli on a somewhat different level fro that of the practicing physician.

Let me touch on how I perso ally perceive the role of the sales representative. These men reach large numbers of health professionals. Thus they could be—anc at times actually are—dissemina tors of useful information. They could consistently serve a real ed cational function in their ability t discuss their products.

At present they do distribut printed material, brochures and pamphlets—some of it scientific ally sound and therefore truly use ful—as well as some excellent fil produced by the pharmaceutical industry. When they function in t

a Source of Information?

Yes, with certain reservations. verage sales representative great fund of information t the drug products he is re- sible for. He is usually able to er most questions fully and igently. He can also supply nts of articles that contain a deal of information. Here, exercise some caution. I usu- ccept most of the statements pinions that I find in the rs and studies which come the larger teaching facilities. s without saying that a physi- should also rely on other es for his information on macology.

ing of Sales Representatives

Ideally, a candidate for the ion as a sales representative harmaceutical company ld be a graduate pharmacist has a questioning mind. I don't this is possible in every case, so it becomes the responsibility of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

---

city they are indeed useful; cularly in the fact that they eminate broadly based educa- al material and serve not just ushers" of their drugs.

Other Side of the Coin

Obviously, the pharmaceuti- ompanies are not producing all material as a labor of love— are in the business of selling ucts for profit. In this regard mbitious and improperly moti- d sales representative can t a negative influence on the ticing physician, both by pre- ing a one-sided picture of his uct, and by encouraging the titioner to depend too heavily rugs for his total therapy. In e ways, the salesman has often orted objective reality and ermined his potential role as an cator.

Industry Responsibility

Since the detail man must be nformation resource as well as presentative of his particular rmaceutical company, he uld be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—*i.e.*, the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that information must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

Pharmaceutical Manufacturers Association
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P·M·A

A message from . . .

The President

A CALL TO ARMS!

In the few years that I have closely observed the official family of The West Virginia State Medical Association, dedication, devotion, loyalty and *service* of its membership have been the hallmark of the organization. Many men and women quickly come to mind.

With each advancing year, opportunities and responsibilities increase at an enormous pace! (Never more than in 1975). The clear conclusion is that there is more attention and work to be given to the Association, and that more manpower is needed.

All of us are busily engaged in *service* to our patients; in this we must always be unfettered. *But*, there are 24 hours in every day for each of us. And, though we are all of the same heritage in this noble profession, and though we experience similar events in our professional lives, we are of different attitudes, opinions and preferences. This is to our benefit, and organization of our Federation comes naturally.

We owe so much to so many generous physicians, spouses and staff who have labored long in the past. We still need you! We also need every breathing soul who practices medicine in West Virginia to think, to speak, to represent, to *serve*.

Bill Gilmore

William E. Gilmore, M. D., *President*

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Editor
GEORGE F. EVANS, M. D.
122 South Sixth St.
Clarksburg, W. Va.

Managing Editor and
Business Manager
MR. WILLIAM H. LIVELY
Box 1031
Charleston, W. Va. 25324

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Wheeling

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EDITORIALS

COMMUNICATION

Hardly a day goes by but what doctors are exhorted to communicate with their patients. This communication is not only for good patient relationships, and so that one may be recognized as practicing modern progressive medicine — but may be mandatory to avoid malpractice suits. I certainly favor communicating with one's patient and making every effort to be sure that she understands her disease and the planned treatment. There are times, however, when I feel very frustrated in attempting this communication.

One of the areas in which I feel this frustration is in deciding upon the type of anesthesia to be used. Given a situation where a decision must be made between the use of general anesthesia or spinal anesthesia, the doctor can only approach his patient with his recommendation. Drawn from years of study, and weighing the imponderables of the situation, he says to the patient that he feels that spinal anesthesia is best in her case.

However, if the patient from some misinformation or misconception fears spinal anesthesia, she has the immediate right to contradict the doctor and veto his decision. For the surgeon to persist in his demand for spinal anesthesia the patient may subsequently sue him and bring charges of assault and battery — particularly if somthing untoward occurs.

Recently in the office I was thinking about communication and resolved to try to make every effort to communicate better with my patients. With these thoughts in mind I inform my patient: "Mrs. Jones, you have a small cyst on the cervix which I will treat with the cautery."

"Cyst! What kind of cyst?", Mrs. Jones replied.

"Well, it's called a Nabothian cyst, Mrs. Jones. That is after the name of the doctor who first described it." I tried to be reassuring.

She raised her head up from the table and fixed me with a beady stare between her knees: "Is it a cancer?"

"No, no, Mrs. Jones," I assured her, "It is just a cystic change in the cervix."

"Oh," she replied, "I've had a cyst before. It was over here on the left ovary, but it never amounted to nothing."

"Well, this is not exactly the same thing. This small cyst is on your cervix."

"Do you mean the cervix is infected?", she asked.

Thoughts of bacteria and viruses and infections like pneumonia filtered through my mind: I replied, "No, it is not exactly an infection; it's an inflammatory change. One of the glands of the cervix has become stopped up and has swollen up to become a cyst."

She was silent a minute as I cauterized the cyst and noticed the glary mucous extrude and cook on the tip of the cautery. I thought about what I had just told her and warmed to my theme: "Mrs. Jones, you know what a blackhead is don't you? Well a blackhead is a gland on the skin of the face that has become plugged and fills with a black sebaceous material. The cyst on your cervix is something like that only the gland can become much larger and fills with a white glary material. In your case the cyst was about as large as the end of my little finger."

I could see the alarm rising in her eyes again. Her pupils dilated slightly, her nose flared and she asked: "Can it turn into cancer?"

Now this is a hard question to answer. I have read articles that showed how inflamed cervices and cervices infected with trichomonas appear to develop cancer more frequently than those that are cared for carefully. However I felt that I was dealing with a high-strung individual who would react hysterically to any such ideas and who would have difficulty in handling the statistics involved in articles that discussed thousands of people in paired groups involving "subjects and controls." Consequently, I said simply that there was no real evidence that Nabothian cysts turned into cancer.

By this time she was sitting up on the end of the table with the sheet wrapped around her while I was trying to write a prescription for Flagyl. Trichomonas had been found in her wet smear.

"Where did I get it?", she asked.

"Get what," I replied thinking of the prescription, "the trichomonas?"

"No," she said, "the cyst."

"Oh, they are fairly common," I said, "Especially in people who are married, are having sexual relations, or who have an infection.

"I am a widow," she replied in a flat voice.

By now I was ready to tear up the prescription and start again having written "q.d." where I had intended to put "q.i.d." I looked her in the eye and said, "I did not mean to imply anything, I was only trying to make the point that Nabothian cysts are very common."

"Oh," she said.

By this time I had somehow lost my enthusiasm for communicating with my patient—so I said: "Nabothian cysts appear to be mucous dilatations of obstructed cervical glands that are of no great pathological significance, but your health will be better if cauterization is performed."

"You mean it's infected," she said.

With a sigh, I thought of the story of Einstein who was asked by his hostess at a tea to explain the theory of relativity. He is reported to have replied, "Madam how would you tell someone who did not know what flour is how to make biscuits?"

However, I kept these thoughts to myself and replied, "Yes, it's infected."

—Guest Editorial by T. Keith Edwards, M. D., Member of the Staff, Department of Obstetrics and Gynecology, Bluefield Sanitarium, Bluefield, West Virginia.

GAINS IN CONTINUING MEDICAL EDUCATION

The American Medical Association's 20th annual compilation of continuing education courses for physicians lists 3,677 courses offered by 876 institutions in 44 states and the District of Columbia in the year September 1, 1974 through August 31, 1975.

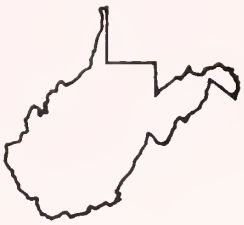
This is a major increase over the number of courses offered in the current year (2,441), and is the largest increase in the number of courses ever reported in a single year, says the report. It was published in the August 12 issue of the *Journal of the American Medical Association.*

The list is published each year as a service to all physicians who are interested in maintaining their competence and skill through formal courses and other organized activities in continuing education.

A major stimulus to continuing education in medicine has been the American Medical Association's Physician's Recognition Award. This is a certificate presented to those who have successfully completed 150 hours of continuing education courses in a three-year period. More than 13,000 physicians qualified for the award in 1973. There are now 24,498 physicians in the United States who hold a valid award.

Eleven state medical associations have adopted programs that may have the effect of requiring continuing medical education as a condition of membership, and others have the subject under consideration. Many of the medical specialty societies also are in process of instituting similar requirements. Four states now have permissive legislation that authorizes a requirement of continuing education as a part of the process of reregistering the license to practice medicine.

GENERAL NEWS



Plans Announced For Eighth Mid-Winter Conference

Plans are under way for the Eighth Mid-Winter Clinical Conference which will be held next January 24-26 in Charleston at the Daniel Boone Hotel.

The Conference will begin Friday afternoon, January 24, and conclude at noon on Sunday, January 26. Drs. Ralph H. Nestmann and Joseph T. Skaggs of Charleston, Co-Chairmen, said there had been a number of requests for the Conference to end earlier on Sunday instead of later in the afternoon as has been the practice.

U. G. Turner, III, M. D.

C. E. Buckley, III, M. D.

Scientific sessions will be held Friday afternoon, Saturday morning and afternoon, and Sunday morning. Following last January's pattern, there will be concurrent sessions on Friday evening. There will be a public session on the "Problems of Adolescents" while physicians attend a session on PSRO entitled "PSRO Revisited One Year Later."

The public session, which again will be sponsored by the Woman's Auxiliary to the Kanawha Medical Society, will explore teenage pregnancies, teenage suicides and drugs and alcoholism. A medically-oriented session on the "Problems of Adolescents," with the same speakers, is scheduled for Saturday morning. One of the speakers for these sessions will be Dr. U. G. Turner, Assistant Professor, Department of Obstetrics and Gynecology, University of Virginia School of Medicine at Charlottesville, where he also is Gynecology Consultant to the Department of Student Health.

Speaking at the PSRO concurrent session Friday evening will be Dr. James C. Respess, Department of Internal Medicine, University of Virginia School of Medicine, and Dr. William C. Felch of Rye, New York, the 1973-74 President of the American Society of Internal Medicine.

The Friday afternoon session will be on heart diseases and will include as one of the speakers Dr. Richard S. Crampton from the University of Virginia Medical Center, whose topic will be "Mobile Coronary Care Unit."

Other speakers and their topics scheduled to date include Dr. Arthur L. Poffenbarger of Charleston, "The Diagnosis and Medical Management of Cerebral Vascular Disease;"

Dr. C. E. Buckley, III, Department of Medicine, Duke University Medical Center (a native of Charleston), "Pulmonary Disease in Adolescents;"

Stanley E. Preiser, Charleston attorney, "How to Avoid Malpractice."

To be announced are additional speakers for vascular diseases and cancer.

The West Virginia University School of Medicine Alumni Association will meet Friday afternoon preceding the evening session.

Physicians, wives and guests will be invited to attend the annual dinner dance of the Kanawha Medical Society Saturday evening at the Daniel Boone.

Also serving on the Conference Planning Com-

Convention Story Will Appear In October Journal

The 107th Annual Meeting of the West Virginia State Medical Association was being held at The Greenbrier in White Sulphur Springs as this issue of *The Journal* went to press.

The full convention story, including information concerning new officers of both the State Medical Association and Auxiliary, as well as heads of sections and affiliated societies and associations, will be carried in the October issue.

mittee with Drs. Nestmann and Skaggs are Drs. William O. McMillan, Jr. of Charleston and C. Carl Tully of South Charleston.

The annual Mid-Winter Conference is sponsored by the State Medical Association in conjunction with some of its component medical groups and volunteer health agencies.

Additional details will be provided in later issues of The Journal as the program takes final shape.

Education — Hospitals Committee Holds Meeting In Charleston

A meeting of the State Medical Association's Committee on Medical Education and Hospitals was held at the Heart-O-Town Motor Inn in Charleston on Sunday, July 14. Dr. Pat A. Tuckwiller of Charleston presided as Chairman of the Committee.

The following members of the Committee were present: Drs. Pat A. Tuckwiller, Chairman, Charleston; William O. McMillan, Jr., Charleston, Vice Chairman; Richard V. Lynch, Jr., Morgantown, Vice Chairman; Charles E. Andrews, Morgantown; Del Roy R. Davis, Kingwood; William E. Gilmore, Parkersburg; Robert D. Hess, Bridgeport; Upshur Higginbotham, Bluefield; and Mary Lou Lewis, Herbert H. Pomerance, Edwin M. Shepherd and Hartwell G. Thompson, all of Charleston.

Others present were J. Randall McCutcheon, Ph.D., Charleston, Director of Continuing Education for the Charleston Division of the West Virginia University Medical Center; Mr. Charles R. Lewis, Charleston, Executive Director of the West Virginia Medical Institute, Inc.; Mr. William H. Lively, Executive Secretary of the State Medical Association, and Mr. Custer B. Holliday, Executive Assistant.

Continuing Education Accreditation

In re accreditation of continuing medical education programs of two hospitals and two specialty organizations, Doctor Andrews moved that the recommendations of the site survey team chairmen and the Review Sub-Committee be approved. The recommendations were: Beckley Appalachian Regional Hospital, full three-year accreditation; West Virginia Academy of Ophthalmology and Otolaryngology, full three-year accreditation; West Virginia Chapter of the American College of Surgeons, full three-year accreditation; and the Veterans Administration Center, Martinsburg, two-year provisional accreditation for a newly-developing program. The motion was unanimously approved.

Doctor Lewis suggested that there should be some way to see that institutions and organizations have better evaluation of their continuing medical education programs.

Doctor Andrews moved that Doctor McCutcheon organize within the next year an appropriate workshop to help representatives of institutions and organizations having responsibilities for continuing medical education develop better methods of evaluation of their CME programs. The motion was passed.

Doctor Tuckwiller reviewed past efforts of the Committee to determine CME needs by regions in the State and raised the question of whether regional CME should be continued.

CME Feedback Wanted

Doctor Thompson, Dean of the Charleston Division of the West Virginia University Medical Center, informed the Committee of the current efforts of the Charleston Division to develop a CME program, noting that the Charleston Division needs feedback from different sections of the State concerning their needs in CME.

There followed some general discussion as to how more interest in CME can be developed.

Doctor Thompson asked Committee members to report back on CME needs in their area at the Annual Meeting of the State Medical Association in August. He reviewed how CME had been planned for in the establishment of the Charleston Division, and then introduced Doctor McCutcheon to the Committee.

Doctor McCutcheon commented that he needs individual physician profiles to see what kinds of things they are doing and raised the question as to whether it might be worthwhile to work in this manner with family physicians.

Mr. Lewis said that the Medical Institute might be able to help Doctor McCutcheon by providing information from some of its programs, such as hospital profiles, which the Institute would be glad to share with Doctor McCutcheon.

There followed a general discussion on recertification requirements of other allied health groups with the observation by Doctor Andrews that nurses, pharmacists and others are better organized in CME and pushing much harder for it than doctors.

Pass Resolution On VOSAS

Mr. Lewis then discussed with the Committee the educational role of the West Virginia Medical Institute, Inc. in the State. He said the Institute had two principal objectives: medical education and the implementation of PSRO. He said the Institute's early CME activity has included assistance to St. Mary's Hospital in Huntington in development of a medical audit system.

Mr. Lewis then explained that the Institute had inherited the Voluntary Office Self-Audit Service (VOSAS) project from the original sponsors, the Medical Association and the West Virginia Reg-

ional Medical Program. He summarized the report, "VOSAS, Evolution of an Experimental Self-Assessment Program in Continuing Medical Education." A copy of this report was given to Chairman Tuckwiller, and Mr. Lewis said additional copies of the report could be obtained from his office. A section of the report was an evaluation of VOSAS based on a survey of physician participants, reviewers and participant/reviewers. The 42 physicians responding were in general positive to quite positive toward VOSAS. Mr. Lewis then asked the Committee to express its feelings as to whether VOSAS was worthwhile and whether it should be continued.

Doctor Lewis then offered a resolution recognizing that VOSAS can be a valuable tool to physicians desiring alternate means of meeting their CME needs, that VOSAS can play an important role in determining the State's CME needs, and proposing that a resolution be introduced in the House of Delegates of the West Virginia State Medical Association recommending that the West Virginia Medcal Institute, Inc. continue development of the Voluntary Office Self-Audit Service program. The resolution was passed.

Changes At WVU Significant

Doctor Andrews reviewed a number of staff changes and additions at WVU which he considered the most significant of any in the last 13 years to the further beneficial development of the medical school. He then briefly reviewed some pending federal legislation which could adversely affect the medical school and individual physicians because of various restrictive controls in the bills. He observed that, if enacted, this legislation could have a profound effect on continuing medical education.

(The Sub-Committee on Continuing Education met prior (10:00 a. m.) to the whole Committee. Members present were Drs. Pat A. Tuckwiller, Robert D. Hess and William O. McMillan, Jr. Absent were Drs. Richard G. Starr, Rowland H. Burns, Joe W. Rhudy and Alfred D. Ghaphery. Also attending were Drs. Thompson and McCutcheon. Doctor Tuckwiller explained the purpose of the formation of the new sub-committee, noting that its members were selected to represent each region of the state. He said he felt a small committee was more effective than a larger group as a mechanism for getting a link with physicians in the field. The sub-committee is to identify regional CME needs and to relate these needs to the newly-developing CME program at the Charleston Division of WVU Medical Center.)

(The Review Sub-Committee also met at 10:00 A. M., prior to the meeting of the whole Committee, and voted approval of the site survey team chairmen's recommendations in re the aforementioned CME accreditations. The sub-committee's recommendations, in turn, were presented to the whole Committee. Those present were Drs. Richard V. Lynch, Jr., Chairman; William E. Gilmore and Mary Lou Lewis. Absent were Drs. George M. Kellas and Richard G. Starr. It was reported to the sub-committee that Doctor Starr had called the office of the State Medical Association prior to the meeting of the sub-committee to give his approval of the recommendations of the site survey chairmen.)

Program Completed For Heart Assn. Meeting In Wheeling

Five separate but interrelated topics will be discussed by a panel at the Scientific Session during the Annual Meeting of the West Virginia Affiliate of the American Heart Association September 27 and 28.

The Annual Meeting will be held at Wilson Lodge at Oglebay Park in Wheeling. The Scientific Session, entitled "Coronary Heart Disease — Modern Evaluation and Treatment," will be from 9 A. M. to Noon on Saturday, September 28.

The panel will include Drs. Creel S. Cornwell of Clarksburg. Murray B. Hunter of Fairmont, Harold Selinger of Charleston and, from the West Virginia University School of Medicine, Drs. Allen F. Bowyer, Abnash C. Jain, David Z. Morgan and Thomas J. Tarnay. Dr. Nanette K. Wenger of Atlanta will be a special guest panelist. Doctor Wenger is Professor of Medicine (Cardiology) at Emory University School of Medicine, and Director, Cardiac Clinics, Grady Memorial Hospital in Atlanta.

Five Sub-Topics Under Theme

The first of the five sub-topics under the general theme of the Scientific Session will be "Evaluation of Risk Factors" ("What are they and how important in the evaluation of office patients?"). Presentation of the concept will be by Doctor Wenger with a Clinical Example given by Doctor Jain. Panel discussion will follow.

The other four sub-topics, with panel discussion to follow in each case, are:

"Coronary Arteriography" ("Who should have it and what does it tell us?"); Presentation, Doctor Bowyer; Clinical Example, Doctor Cornwell;

"Collateral Vessels" ("When do they develop and how do they preserve the myocardium following coronary occlusion?"); Presentation, Doctor Jain; Clinical Example, Doctor Hunter;

"Medical Treatment" ("What drugs and who should be given medical management?"); Presentation, Doctor Selinger; Clinical Example, Doctor Morgan;

"Surgical Treatment" ("Who are candidates for revascularization; what are the current best tech-

niques; what is the natural history of the by-pass?"); Presentation, Doctor Tarnay; Clinical Example, Doctor Bowyer.

Registration for the Annual Meeting will begin at 10 A. M. on Friday, September 27, with the General Assembly convening at 2 P. M. The keynote address will be delivered by Dr. Leo H. T. Bernstein of Martinsburg, President-Elect.

Native Of New York City

Doctor Wenger will address the annual membership banquet Friday evening. A native of New York City, she graduated from Hunter College in New York and received her M. D. degree in 1954 from Harvard Medical School. She interned at Mount Sinai Hospital in New York City, where she also served residencies in medicine and cardiology. In 1958 she became Senior Assistant Resident in Medicine at Grady Memorial Hospital in Atlanta and a Fellow in cardiology at Emory University.

Doctor Wenger is a Fellow of the American College of Cardiology, the American Heart Association's Council on Clinical Cardiology, and is a member of a number of other AHA committees. She is the author or co-author of almost 100 scientific publications, including "Coronary Care Rehabilitation After Myocardial Infarction." This was a 1973 publication of the Coronary Care Committee of the Council on Clinical Cardiology, the Committee on Medical Education, American Heart Association.

Ross Reid of New York City, Chairman of the Board of the American Heart Association, will speak at the Awards Luncheon on Saturday. This will be followed by panel discussion groups and the second General Assembly in the afternoon. The program will conclude with a Board of Directors dinner meeting Saturday evening.

The Wheeling Clinic Announces 'Golden Jubilee' Program

The program has been completed for the "Golden Jubilee" Scientific Seminar of the Wheeling Clinic to be held October 18-19 at Oglebay Park in Wheeling.

The two-day seminar in medicine and surgery will begin with a round-table conference Friday morning, October 18. The speakers and their topics will be "Psychiatric Problems in the Aging," Wilford W. Spradlin, M. D., Chairman of the Department of Behavioral Medicine and Psychiatry at the West Virginia University Medical Center; and "Recognition and Management of Spasticity," Richard Herman, M. D., of Philadelphia, Chairman and Professor of the Department of Rehabilitation Medicine at Temple University School of Medicine; and Director of the Krusen Center For Research and Engineering, Moss Rehabilitation Hospital in Philadelphia.

The Moderator will be A. L. Wanner, M. D., of the Department of Psychiatry, Neurology and Psychology at the Wheeling Clinic. Other members of the clinic staff participating will be Drs. Stephen D. Ward, David H. Smith, Michael D. McNeer, David P. Hill and Robert L. Mendelson, Ed. D.

Doctor Andrews Luncheon Speaker

"Changing Concepts in Medical Relationships" will be the subject of the luncheon speaker, Dr. Charles E. Andrews of Morgantown. Doctor Andrews is Provost for Health Services at the WVU Medical Center. Dr. Milton E. Nugent, Chairman of the Wheeling Clinic Executive Committee, will preside at the luncheon.

Friday Afternoon

Scheduled for Friday afternoon is a round-table

Wilson Lodge, left, will be the site at Oglebay Park in Wheeling for the Wheeling Clinic's Golden Jubilee Scientific Seminar in Medicine and Surgery on October 18 and 19. On the right is the landmark for the Park, the historic Oglebay Mansion Museum. Tours of the museum will be a part of the ladies program arranged by the Auxiliary of the Wheeling Clinic. The Clinic is celebrating 50 years of operation during 1974.

William J. Holloway, M. D.

Rupert B. Turnbull, M. D.

Richard Herman, M. D.

Wilford W. Spradlin, M. D.

conference in internal medicine which will include five topics. Charles H. Hiles, M. D., Department of Internal Medicine, Wheeling Clinic, will be Moderator. A question-and-answer period will be conducted after each topic. The speakers and their topics are:

"Dilemmas of Hypertensive Therapy," Michael F. Michelis, M. D., Chief Director, Diagnostic USVA, Pittsburgh; and Associate Professor of Medicine, University of Pittsburgh; "Current Concepts in the Treatment of Peptic Ulcer," Thomas E. Chvasta, M. D., Department of Internal Medicine, Wheeling Clinic; "Pacemakers," A. M. Valentine, M. D., Department of Internal Medicine, Wheeling Clinic; "Birth Control Pills, Folic Acid and Pap Smear," Robert W. Kellermeyer, M. D., Associate Professor of Medicine and Pharmacology, University Hospitals of Cleveland (Ohio), and "The Treatment of Diabetes in Pregnancy," Jerome H. Aarons, M. D., Magee Womens Hospital, Pittsburgh.

Friday Evening

Friday's schedule will conclude in the evening with cocktails and a dinner-dance.

Saturday Morning

Sectional Conferences will be held Saturday morning. Drs. William C. Andrews and H. Robert Holtrop will be guest speakers at the conference on obstetrics and gynecology. Doctor Andrews is Associate Professor of Obstetrics and Gynecology at Eastern Virginia Medical School in Norfolk. His topic will be "Current Status of Contraception." Doctor Holtrop formerly was with the Wheeling Clinic and now is located in Boston.

The Moderator will be Robert W. Leibold, M. D., Department of Obstetrics and Gynecology, Wheeling Clinic. Other clinic staff members participating will be Drs. Robert T. Brandfass, A. Athari and James W. Campbell.

Other sectional conferences and the Wheeling Clinic staff members presiding include "Thoracic Medicine," Dr. Daniel W. Dickinson, Department of Surgery; "Dermatology," Drs. Sheldon Widlan and K. William Waterson, Department of Dermatology; "Otolaryngology," Dr. Wilfredo A. Tiu, Department of Otologic Surgery and Othorhinolaryngology, and James P. Frum, M. S., Department of Audiology and Speech Pathology; "Ophthalmology," Drs. William F. Park, Milton E. Nugent and R. V. Pangilinan, all from the Department of Ophthalmology.

Dr. Charles D. Hershey, Department of Surgery, will be Moderator for the conference on surgery. Guest speakers and their topics will be "Local Treatment of Small Cancers of the Rectum," Rupert B. Turnbull, M. D., Department of Colon and Rectal Surgery, Cleveland Clinic; and "Acute Therapy of Major Burns," Harvey Slater, M. D., West Penn Burn Center, Pittsburgh.

Saturday Afternoon

A round-table conference will be held Saturday afternoon with Doctor Pangilinan as the Moderator. The speakers and their topics will be "Antibiotic Selection In the Critically Ill Patient," Dr. William J. Holloway of Wilmington, Delaware, Director of the Infectious Diseases Research Laboratory at the Wilmington Medical Center; and "Venereal Disease — Can It Be Prevented?," Dr. Hans H. Neumann, Director of Preventive Medicine for the Department of Health in New Haven, Connecticut. A question-and-answer period will be held after each of these topics.

Saturday Evening

The Saturday evening schedule will include cocktails and dinner followed by a special guest speaker to be announced.

For wives, the Auxiliary of the Wheeling Clinic has arranged tours of various features at Oglebay Park and other interesting spots in the Wheeling area. Ample time has been allotted for recreational activities.

The meeting has been approved for 12 hours of credit by the American Academy of Family Physicians and the registration fee for the entire conference is $25. Registration will be limited to 100 physicians.

Dr. C. Carl Tully, left, Director of the Kanawha Valley Family Practice Center, is shown with the five residents on the Center staff during an open house held at the new facility in South Charleston this summer. The residents are, from left, Dr. William L. Harris of Fenwick, in Nicholas County, Dr. Donald A. Blum of New Martinsville, Dr. Richard D. Hayes, Jr. of Nitro, Dr. John P. MacCallum of Madison, and Dr. James L. Kwako of Bismarck, North Dakota, all graduates of West Virginia University's School of Medicine.

Family Practice Residency Program Begins Smoothly

West Virginia's first Family Practice residency program has been moving through its orientation phase smoothly.

Dr. John W. Traubert, Chairman of the recently established Department of Family Practice at the West Virginia University School of Medicine, said all of the nine young doctors approved for the three-year specialty medical program in Morgantown and in the Kanawha Valley have been in residence since July.

Dr. Patrick Kelleher arrived at WVU on time after a 10-day, 900-mile bicycle trip from his home in Vermont. He joined Drs. Michael J. Lewis of Charleston, David W. Nesselroade of Williamstown and Dale J. Luketich of Weirton, all 1974 WVU graduates.

The other five residents are in the Kanawha Valley program directed by Dr. C. Carl Tully of South Charleston. He will supervise training centered at Herbert J. Thomas Memorial Hospital. The Charleston Area Medical Center will provide the medical specialty guidance.

The residents in the Kanawha Valley program are Drs. Donald A. Blum of New Martinsville, William Harris of Fenwick, in Nicholas County; Richard D. Hayes of Nitro, John P. MacCallum of Madison and James Kwako of Bismarck, North Dakota.

Doctor Traubert said all of the young physicians have expressed a desire to establish a medical practice in the State. During their residency, they will get a chance to go into communities without medical practitioners as part of their elective work.

The West Virginia Academy of Family Physicians sees the new program as a major contribution toward relieving the State's present doctor shortage within the next 10 years.

WVU Medical Center Conducting Chemotherapy Studies

The Department of Medicine of the West Virginia University Medical Center is conducting chemotherapy studies in women with breast carcinoma who have recently had a mastectomy and have four or more axillary nodes positive for tumor. These patients should be seen within one month after the surgery and should have had no radiation therapy. Physicians interested in referring patients for this study which is being done in cooperation with the National Cancer Institute should contact Dr. Raymond B. Weiss or Dr. Lowell Smith at the Medical Center. Telephone (304) 293-4229 or 293-4536.

WVU School of Medicine Greets Class of '77

Thirteen women, the largest number ever admitted in one year, are among the 84-member class which entered the West Virginia University School of Medicine when the fall semester began on August 26.

Reflecting the preference given to West Virginia residents, 82 of those selected are from the State.

One of the out-of-state residents named is WVU graduate Ade Dillon, former varsity football team quarterback. He is a native of Wisconsin.

Selection, based on scholastic standing, Medical College Admission Test scores and the results of interviews, was again a difficult task for the 12-member Committee on Student Admissions.

More than 1,400 inquiries were received by the School of Medicine concerning admission. Of this number, 656 firm applications were made. Further screening resulted in interviews for 283 West Virginians and 40 non-residents, including nine residents of foreign countries.

Overall cumulative grade point average for the 84 admitted was 3.49 with a science GPA of 3.53.

Undergraduate study was completed at WVU by 46 of the accepted students. The remainder are graduates of either Marshall University or eight colleges within the State or from 25 out-of-state institutions.

Counties providing the most medical students weer Kanawha, with 14, and Cabell, nine.

Those accepted for the 1974 freshmen class in the WVU School of Medicine include:

BARBOUR COUNTY—Ernest Samuel Guy, Morgan Hertzog Lyons, Jr., and Jeff Lee Poling, all of Philippi.

BRAXTON COUNTY—David Wayne Thomas of Sutton.

BROOKE COUNTY — Patsy Paul Cipoletti, Jr., Wellsburg.

CABELL COUNTY — John Robert Beatty, Lawrence Stuart Gross, David Arthur Guthrie, John Michael Haught, Joseph Moore Neal, William Neil Payne, II, Charles David Petit, Richard Glenn Spurlock and Susan Kathryn Woelfel, all of Huntington.

DODDRIDGE COUNTY—Donald Hastings Michels, West Union.

FAYETTE COUNTY — Gregory Lee Eads, Kincaid; and Thomas William Howard, II, Mount Hope.

GILMER COUNTY — Larry J. Godfrey, Glenville.

GRANT COUNTY—Gordon Keith Wolfe, Petersburg.

GREENBRIER COUNTY—Sheila Joan Walkup, Leslie.

HANCOCK COUNTY—Charles Peter Capito, James Richard Judge, Jr., and Mark Christopher Leeson, all of Weirton.

HARRISON COUNTY—Robin Kim Conner, Anmoore; Joseph Carl Franz, Janis Leigh Hurst, David Henry McDaniel and John Michael Rollins, all of Bridgeport; Virginia Robbins Beall, Ronald Lee Cleavenger and Pamela Joan Mardones, all of Clarksburg.

JACKSON COUNTY—James Carter Jarrell, Ravenswood.

JEFFERSON COUNTY—Edward Joseph Gallagher, Shepherdstown.

KANAWHA COUNTY—Billy Franklin Gardner, III, Belle; Stephen Paul Casiss, Malcolm Lindsay Chaney, Paul Frederick Francke, Robert Craig Armstrong Gilpin, David Craig McCarus, George Edward Pritt, II, Richard Arrington Silman, Deborah Ann Willard and Patricia Joan Zekan, all of Charleston; Marilyn Ann Martin, Glasgow; William Kent Hamilton, Nitro; John Andrew Hostler and Peter Joseph Lukowski, South Charleston.

LEWIS COUNTY—Andrew Harold Mace, Jr., Weston.

MARION COUNTY—John Joseph Astrino and Richard Ellison McWhorter, Fairmont; Ellen Susan Shaw, Monongah.

MARSHALL COUNTY—Patricia Rae Corrall and Thomas Oscar Dickey, Glendale.

MERCER COUNTY—David Alan Bowman, Michael Anthony Malamisura and Bruce Neal Nelson, all of Bluefield; Terry Lee Barrett, Princeton.

MINERAL COUNTY—James Marshall Carrier, Keyser.

MONONGALIA COUNTY—Robert Wesley Farr, Mark Kelly Joy, Lucille K. Kirchner, Rodney Frederick Kovach, Jerry Ewing Squires and Thomas Linson Warren, all of Morgantown.

NICHOLAS COUNTY—Norman Leon Rexrode, Summersville.

OHIO COUNTY—Richard William Ball, Triadelphia; Edwyn Lee Boyd, Robert Earl Gaylor, Jeffrey Stewart Hallett, Dale Robert Pokorney and Charles John Singer, all of Wheeling.

PENDLETON COUNTY—George Edward Lovegrove, Franklin.

PRESTON COUNTY—James H. L. Beeghly, Bruceton Mills; James Curtis Lesnett, Kingwood.

RALEIGH COUNTY—William Cecil Thompson, III, Beckley.

SUMMERS COUNTY—Robert Edward Boyd, Talcott.

TYLER COUNTY—John Charles Young Wright, Jr., Sistersville.

WETZEL COUNTY—Edward Eugene Wright, Pine Grove; and Gary Allen Kocher, Reader.

WOOD COUNTY—Jay David Angeluzzi and Frank Lee Schwartz, Parkersburg; Eleanor Jo Allen, Williamstown.

Members of the class from out-of-state are Charles William Gardner, Virginia Beach, Virginia, and Ade Robert Dillon, Appleton, Wisconsin.

Exam Applications Soar, ABFP Directors Hear

Announcement that more than 1,700 family doctors have applied to take the October examination, a reaffirmation of the 1978 cutoff date for practice-eligible candidates, a statement on "lateral mobility" among primary-care residencies, and a definition of "board eligibility" were highlights of the interim meeting of the American Board of Family Practice (ABFP) July 19-20 at Colorado Springs.

ABFP is the certifying board in family practice. It was approved by the American Board of Medical Specialties and the Council on Medical Education of AMA in February, 1969. More than 5,800 family doctors have been certified since its first examination in 1970.

According to Dr. Arthur Nelson, ABFP President, the heavy registration of applicants resulted from an increase in residency graduates and an apparent "recognition on the part of Academy of Family Physicians members that board certification will affect their future."

Doctor Nelson noted that the directors upheld an earlier decision that 1978 would mark the end of a practice-eligible category of diplomate candidates. However, he said, it was decided to change the effect date from January 1, 1978, to July 1, 1978. He added that this was done to make the changeover coincide with the graduate education wheel.

The board of directors adopted part of a statement on "lateral mobility," a concept aimed at permitting interchange after the first year between family practice residencies and residencies in internal medicine and pediatrics and possibly other primary-care specialties. The adopted portion: "The American Board of Family Practice reaffirms its position that all three years of the family practice residency should be under the direct supervision of the director and his faculty. The importance of the resident having a learning experience in a family practice center throughout all three years is recognized and stressed."

Doctor Nelson said the remainder of the statement dealt with methodology for achieving lateral mobility. He added that input would be sought from AAFP, the AMA Section on Family/General Practice and the Residency Review Committee for Family Practice before considering the full statement at the ABFP's annual meeting next January.

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled in the coming months.

1974

Sept. 4-7—Am. Assn. Ob.-Gyn., Hot Springs, Va.
Sept. 5-7—Tri-State Otolaryngology Meeting, Sea Island, Ga.
Sept. 9-11—AMA Congress Occupat. Health, Chicago.
Sept. 18-20—Int. Symp. Epidemiology of Hypertension, Chicago.
Sept. 18-21—Am. Thyroid Assn., St. Louis.
Sept. 20-21—Symp. on Neonatology, El Paso.
Sept. 24-26—Kentucky Medical, Louisville.
Sept. 24-27—Am. Roentgen Ray Soc., San Francisco
Sept. 27-28—Am. Heart Assn., W. Va. Affiliate, Annual Meeting & Scientific, Wheeling.
Sept. 27-Oct. 2—Internat. Coll. of Surgeons, Portland.

Oct. 5-8—Am. Assn. of Ophthalmology, Dallas.
Oct. 6-10—Am. Acad. Oph. & Otol., Dallas.
Oct. 14-17—AAFP, L. A.
Oct. 16-18—Am. Cancer Society, New York.
Oct. 17-19—Am. Assn. for Surgery of Trauma, Hot Springs, Va.
Oct. 18-19—Golden Jubilee Sem. In Med. and Surgery (Wheeling Clinic), Wheeling.
Oct. 19-24—Am. Acad. Pediatrics, San Fran.
Oct. 20-22—Am. Coll. Preventive Med., N. Orleans.
Oct. 21-25—ACS Clinical, Miami Beach.
Oct. 21-26—Am. Coll. Gastroent., Bal Harbour, Fla.
Oct. 23-26—Pa. Medical Soc. Scientific, Harrisburg.
Oct. 24-27—Am. Acad. Child Psychiatry, San Fran.
Oct. 29-30—Am. Assn. Study of Liver Diseases, Chicago.

Nov. 1-3—Med. Soc. of D. C., White Sul. Springs.
Nov. 3-6—Med. Soc. Va., Williamsburg.
Nov. 6-9—Am. Soc. Cytology, N. Y. City.
Nov. 14-16—W. Va. Chap., ACS, Morgantown.
Nov. 16-20—Amer. Acad. for Cerebral Palsy, Denver.
Nov. 17-20—Southern Med Assn., Atlanta.
Nov. 21-24—Clinical Immunology and Allergy, Ft. Lauderdale, Fla.
Nov. 30-Dec. 4—AMA Clinical, Portland.

Dec. 7-10—Am. Soc. Hematology, San. Fran.
Dec. 7-12—Am. Acad. Dermatology, Chicago.
Dec. 9-12—Southern Surgical Assn., Atlanta.

1975

Jan. 24-26—8th Annual Mid-Winter Clinical Conf., Charleston.
Jan. 31-Feb. 2—Southern Radiological Conf., Point Clear, Ala.

Feb. 10-13—Am. College Cardiology, Houston.

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THE FACULTY WILL INCLUDE:

Richard Herman, M. D., Temple University
Michael F. Michelis, M. D., University of Pittsburgh
Robert W. Kellermeyer, M. D. University Hospitals of Cleveland
Charles E. Andrews, M. D. West Virginia University Medical Center
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Hans A. Neumann, M. D. New Haven, Connecticut
Rupert B. Turnbull, M. D. Cleveland Clinic
Harvey Slater, M. D., West Penn Burn Center, Pittsburgh, Penna.
William C. Andrews, M. D., Eastern Medical School, Norfolk, Virginia

THE REGISTRATION FEE of $25.00 for the entire conference will be charged all registrants and will include admission to luncheon on Friday and Saturday and evening entertainment and dinner for the registrants **and** their wives on Friday **and** Saturday.

LADIES PROGRAM:

The Auxiliary of the Wheeling Clinic has arranged for tours (of the historic Oglebay Mansion House, Museum and Art Gallery; and, of a Handcraft Glass Plant) for those who are interested. Also, golf or tennis, plus plenty of "free" time.

OVERNIGHT ACCOMMODATIONS

Registrants are responsible for their own lodging at their choice of hotel or motels. A block of rooms is available (on a first-come first-served basis) at Wilson Lodge in Oglebay Park and you may contact Mr. **Russ Bond at 242-3000.**

--------Mail to: Golden Jubilee Committee, Wheeling Clinic, Wheeling, W. Va. 26003--------

Please register me for the Golden Jubilee Seminar of the Wheeling Clinic, October 18th and 19th. My registration fee of $25.00 is enclosed. I understand the registration is limited to One Hundred Physicians.

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(Please Print)

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SATURDAY NIGHT SPEAKER: DAVID BRINKLEY

WVU Medical Center
–News–

THE appointment of Dr. Dale D. Lindholm as Professor of Medicine and Chairman of the recently-established Division of Nephrology at the West Virginia University Medical Center has been announced by WVU President James G. Harlow.

Prevention, diagnosis and the medical management of kidney disease will be the emphasis of the new teaching and clinical service within the Department of Medicine.

Doctor Lindholm comes to WVU from Tulane University where he was Head of the Section of Kidney Disease at the School of Medicine and Chief of the Nephrology Section at the Department of Medicine at the New Orleans Veterans Administration Hospital.

A native of Duluth, he received his bachelor's and M. D. degrees from the University of Minnesota and completed his internship at St. Luke's Hospital in Duluth. During the eight years he was a commissioned officer with the United States Public Health Service, he completed his residency in internal medicine at the USPHS Hospital in Seattle and also was a National Heart Institute Research Fellow in nephrology at the University of Washington School of Medicine and Chief of Research at the USPHS Hospital and Seamen's Memorial Research Laboratory in New Orleans.

He is a member of a number of professional societies including the American and International Societies of Nephrology, The Southeastern Dialysis and Transplantation Association and the Association of Veterans Administration Renal Physicians.

He is the author or co-author of more than 30 scientific articles, most of them concerning kidney disease and hemodialysis and their effect on the body.

Former WVU Residents Return

Two former residents at West Virginia University Hospital have returned to the Medical Center as assistant professors in the School of Medicine.

Dr. Douglas V. Jewson, who holds his appointment both in the Departments of Surgery and Medicine, will be a full-time member of the emergency room staff.

A native of Minneapolis, he received his B. A. and M. D. degrees from the University of Minnesota before coming here for his internship in 1966. After completing his residency in internal medicine, he spent an additional year at the Medical Center as a Fellow in cardiology.

• **Compiled from material furnished by Mrs. Mary Ellin Wylie, Director, Medical Center News and Information Services, Morgontown, W. Va.**

Prior to opening a private practice in Duluth, Minnesota, he served two years as a major in the United States Army Medical Corps at Irwin Army Hospital in Fort Riley, Kansas.

Also a native of Minneapolis and a graduate of the University of Minnesota is Dr. Irma H. Ullrich. She will serve as Assistant Professor in the Division of Metabolism - Endocrinology, Department of Medicine.

After serving both her internship and residency at WVU, she spent the past year as a Fellow in endocrinology and an Instructor in Medicine at the VA Hospital and Medical University of South Carolina in Charleston.

TV Health Series Coming

More than 60 of the state's health, program and civic leaders met recently at West Virginia University's Coliseum to help promote and find ways to best utilize "Alive and Well," the upcoming television series that has been termed "probably the boldest single attempt at mass health education by the media."

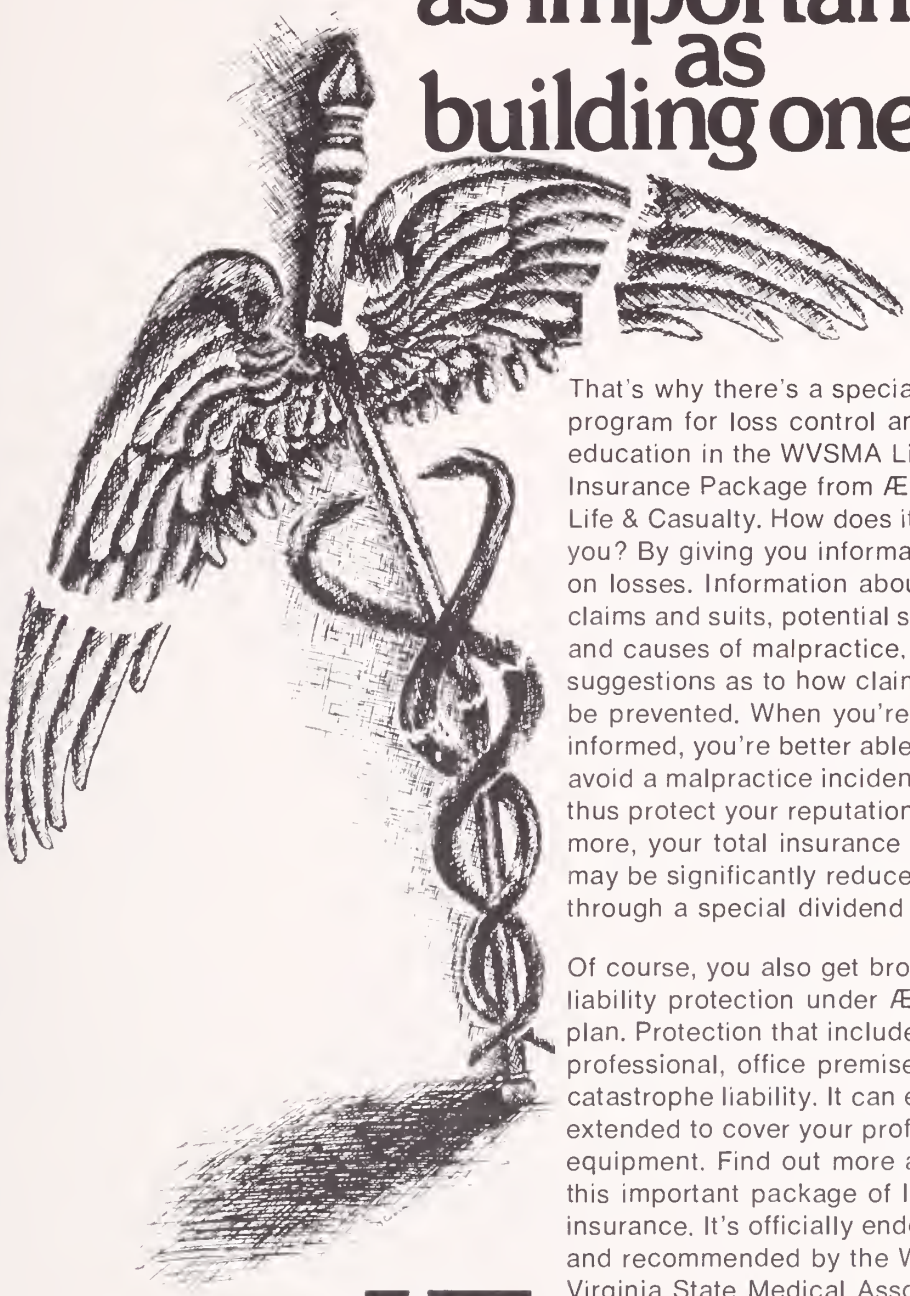
The complete "Alive and Well" series may be seen on WWVU-TV, the University-operated public non-commercial television station that serves northern and eastern West Virginia.

Hosts for the planning session were WWVU-TV staff members concerned both with informing viewers about the series and mobilizing the local responses to inquiries for help which the programs are expected to stimulate.

First of the 26 hour-long programs, produced in New York for the Public Broadcasting Service by the Children's Television Workshop. is set for 8 P. M. Wednesday, November 20, with a repeat showing scheduled at 5:30 P. M., Sunday, November 24.

Creators of "Sesame Street" and "The Electric Company," the CTW producers have used similar entertainment techniques for their first adult programs. Singing, dancing, documentaries and situation comedy, much of it featuring stage, motion picture and television personalities, will be employed on the health series each week to treat subjects ranging from nutrition to exercise and from hypertension to breast self-examination.

Protecting a reputation is as important as building one.



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The Month in Washington

• **From the Washington Office of the American Medical Association.**

CHANCES of passage this year of any national health insurance (NHI) proposal by either the Senate or the House seem to be dwindling away. The indefinite postponement of Senate Finance Committee hearings on NHI, plus the now ended lackluster once-a-week hearings by the House Ways and Means Committee that dragged out through the Spring and early Summer seems to indicate the Congress feels it has more pressing matters to deal with, or is baffled as to how to proceed with mandating health insurance for all.

Some veteran Capitol Hill observers believe the most important factor in congressional dawdling on the NHI issue is genuine bafflement — which has led to sharp controversy — on how such a program should be financed.

Most of the NHI proposals vary little in the scope of benefits. And there is no sharp disagreement that the program should be comprehensive in nature. And all but one or two of the proposals agree that the administration of the program should be derived from a combination of the federal and private sectors, using the existing private health insurance industry, controlled by federal guidelines and regulations.

The catch comes as to how the program should be financed. Should the program be financed by a Social Security payroll tax, or by mandated employer-employee financing, or by a tax credit system, such as proposed by the American Medical Association in its Medicredit plan?

It is in the area of financing that conservatives find the dangers of NHI. When a program is financed directly through federal revenues, it is an open invitation for government to use those dollars as a lever to manipulate the entire program —"an inappropriate intervention of the federal government into private affairs and responsibilities".

Each of the proposed methods for financing a NHI program has powerful allies, both in the Congress and in the private sector. And it would seem that this Mexican standoff is a major reason for this Congress' delay. Short of an unlikely compromise brought on by a complete about face by one of the major contending forces, it would appear that the 93rd Congress will not legislate a national health insurance program.

Another reason for congressional foot-dragging on NHI is that time is running out for the 93rd Congress and its "must" work is still piled high. For example, still to surface from the powerful House Ways and Means Committee is its promised tax reform measure, the long ago announced number one priority of the Committee.

And overshadowing all congressional priorities is the loom of time-consuming impeachment proceedings on the near horizon. "If the House votes to impeach President Nixon, forget national health insurance this year," says Sen. Abraham Ribicoff (D-Conn.), sponsor of a leading NHI bill.

'Public Utility' Plan Defeated

The House's Interstate and Foreign Commerce sub-committee on health has crushed by an 8 to 1 vote a public utility-like plan that would control physician fees and hospital charges, a provision regarded by many as the most threatening health measure on Capitol Hill.

The vote appeared to assure the doom of the public utility concept both in the full House Commerce Committee and the House. There remains the possibility of Senate approval, however.

The controversial provision is part of a comprehensive and complicated rewriting of the Comprehensive Health Planning and Regional Medical Programs of the federal government. The proposed strict rate controls exercised by the states are backed by Sen. Edward Kennedy (D-Mass.) and Rep. William Roy (D-Kans.), the latter a physician who cast the lone vote for the provision in the House sub-committee.

The vote was on a motion to strike from the bill language that would have authorized federal funding for State Health Commission programs of regulating charges in the medical field with ultimate authority in the HEW Department.

Health providers have opposed the plan. Declaring that the legislation has "far reaching implications for the future delivery of health care services," Richard Palmer, M.D., Chairman of the American Medical Association's Board of Trustees, told the sub-committee earlier this year that under the disputed plan "the health sector in effect would be deemed to be one vast, monolithic public utility."

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Precautions: In the elderly and de- tated, and in children over six, limit to allest effective dosage (initially 10 or less per day) to preclude ataxia or rsedation, increasing gradually as ded and tolerated. Not recommended hildren under six. Though generally recommended, if combination therapy other psychotropics seems indicated, efully consider individual pharmaco- ic effects, particularly in use of poten- ing drugs such as MAO inhibitors d phenothiazines. Observe usual precau- ns in presence of impaired renal nepatic function. Paradoxical reac- ns (e.g., excitement, stimulation and ite rage) have been reported in psychi- ic patients and hyperactive aggressive ldren. Employ usual precautions in treat- nt of anxiety states with evidence of pending depression; suicidal tendencies y be present and protective measures essary. Variable effects on blood gulation have been reported very rarely patients receiving the drug and oral icoagulants; causal relationship has been established clinically.

Adverse Reactions: Drowsiness, xia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in and/or severity of grand mal se require increased dosage of sta convulsant medication; abrupt may be associated with tempor crease in frequency and/or sev seizures. Advise against simulta gestion of alcohol and other CN sants. Withdrawal symptoms (s those with barbiturates and alc occurred following abrupt disco (convulsions, tremor, abdomina cle cramps, vomiting and sweat addiction-prone indlviduals unc

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than in a week or

two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

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For further information on this subject, the following references are provided:

1. Henry BW, *et al: Dis Nerv Syst 30*:675-679, Oct 1969.
2. Hollister LE, *et al: Arch Gen Psychiatry 24*:273-278, Mar 1971.
3. Claghorn J: *Psychosomatics 11*:438-441, Sept-Oct 1970.

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in psychoneurotic
anxiety states
with associated
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sual precautions indicated in
erely depressed, or with latent
or with suicidal tendencies.

Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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OCTOBER
1974

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The
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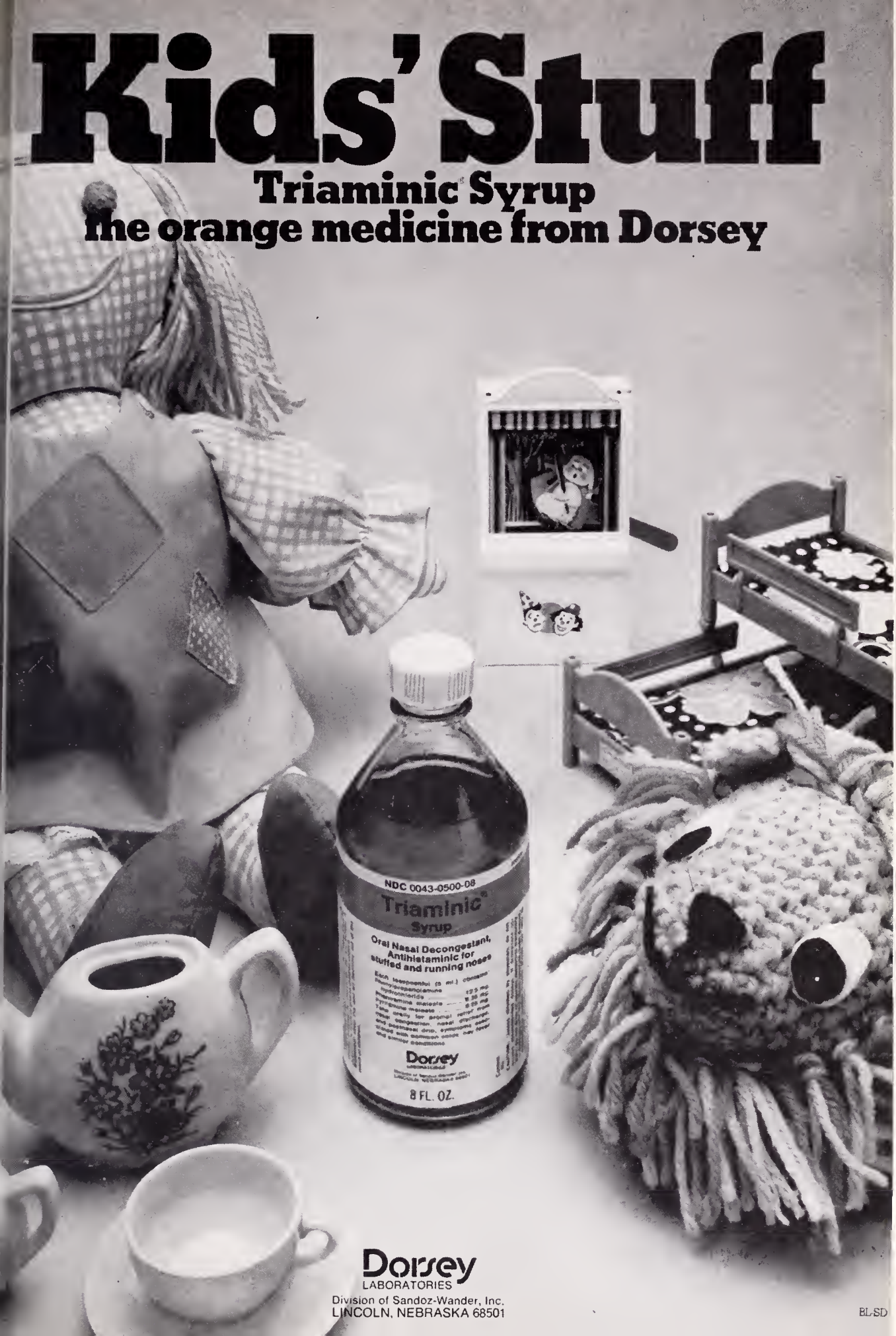

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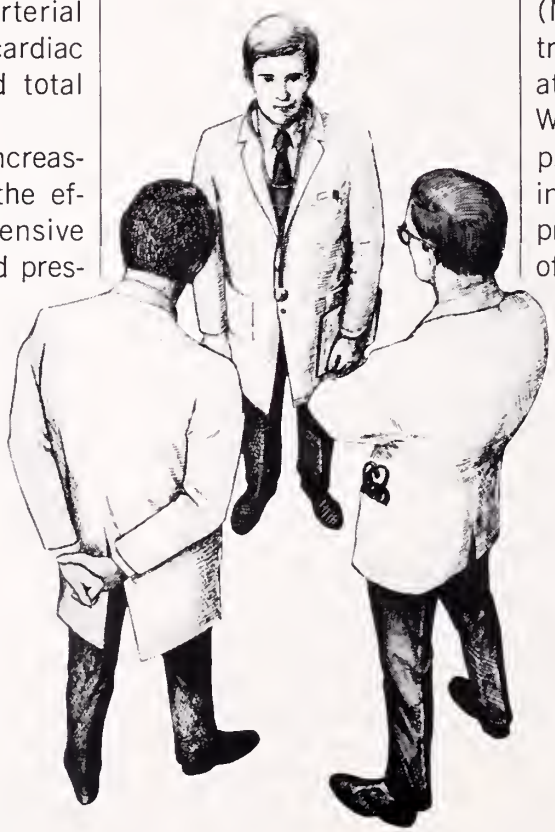

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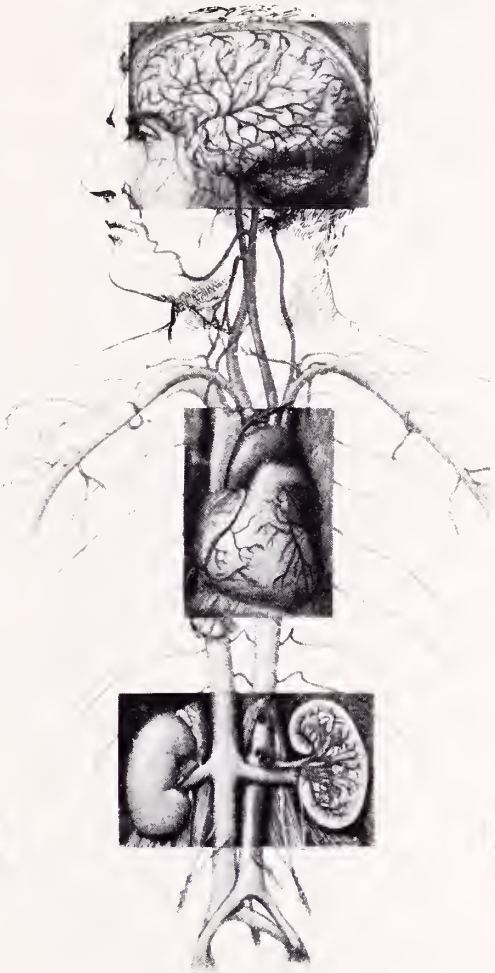

owering blood pressure. But here are other considerations s well. Cardiac output is usu- lly maintained with no cardiac cceleration; in some patients he heart rate is actually lowed. Peripheral resistance s apparently reduced. ALDOMET does not usually ompromise existing renal unction; it generally does not educe renal blood flow, glo- nerular filtration rate, or fil- ration fraction. And ALDOMET usually does not cause sympto- natic postural or exercise ypotension.

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It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. For more details see the brief summary of prescribing information.

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Contraindications: Active hepatic disease, such as acute hepatitis and active cirrhosis. Known sensitivity. Not recommended in pheochromocytoma. Unsuitable in mild or labile hypertension responsive to mild sedation or thiazide therapy. Use cautiously in patients with history of previous liver disease or dysfunction.

Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between six and twelve months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at six and twelve months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first three weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first two to three months of therapy. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first six to twelve weeks of therapy or whenever an unexplained fever occurs. If fever, abnormalities in liver function tests, or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, reversible reduction in leukocyte count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur.

Use in Pregnancy and Childbearing Age—Not recommended in pregnancy. In women of childbearing age, weigh potential benefits against possible fetal hazards.

Precautions: Methyldopa may interfere with measurement of: uric acid by the phosphotungstate method, creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, spuriously high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has occurred after dialysis in patients on methyldopa because the drug is removed by this procedure.

Adverse Reactions: Sedation, usually transient, may be seen during initial therapy or when dosage is increased. Headache, asthenia, or weakness may be noted as early, transient symptoms. Symptoms associated with effective lowering of blood pressure are occasionally seen and include dizziness, lightheadedness, and symptoms of cerebrovascular insufficiency. Angina pectoris may be aggravated. Symptoms of orthostatic hypotension may occur; if symptoms occur, reduction of dosage is suggested. Bradycardia, nasal stuffiness, mild dryness of mouth, and gastrointestinal symptoms including distention, constipation, flatus, and diarrhea occur occasionally; these generally can be relieved by reducing dosage. Nausea and vomiting have been reported in only a few patients. Sore tongue or "black tongue," pancreatitis, and inflammation of salivary glands may occur.

Weight gain and edema occur infrequently and are relieved by administering a thiazide diuretic; if edema progresses or signs of pulmonary congestion appear, discontinue drug. A rise in BUN has been observed. Other rare reactions include breast enlargement, lactation, impotence, decreased libido, skin rash, mild arthralgia, myalgia, paresthesias, Bell's palsy, parkinsonism, psychic disturbances including nightmares, reversible mild psychoses or depression. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Note: Dosage should be limited initially to 500 mg daily when following previous antihypertensive agents other than thiazides. Maximal recommended daily dose is 3.0 g. Patients with impaired renal function may respond to smaller doses than patients with normal kidney function. Syncope in older patients has been related to increased sensitivity in those with advanced arteriosclerotic vascular disease; this may be avoided by lower doses. Tolerance occasionally seen either early or late, but more likely between second and third month after initiation of therapy; increased dosage or combined therapy with a thiazide frequently restores effective control.

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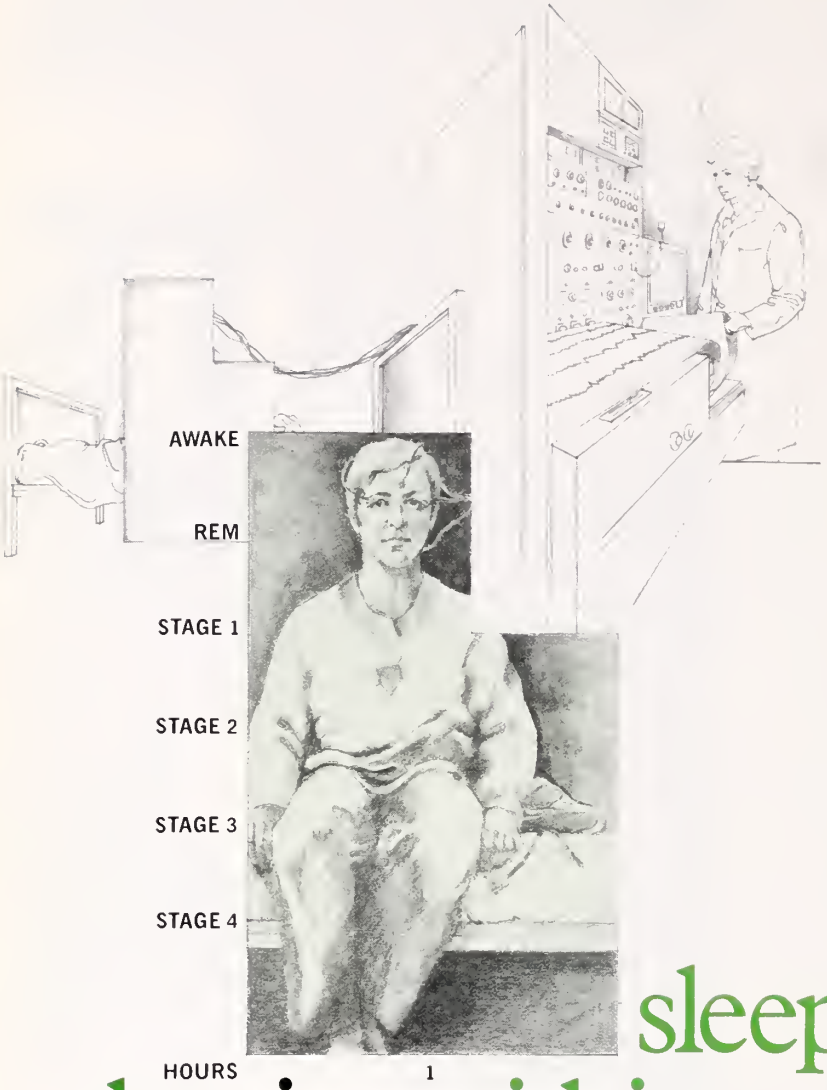


sleep begins within 17 minutes, on average ...

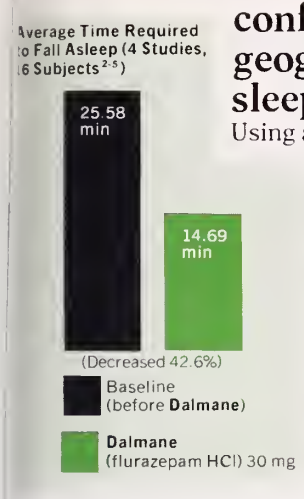
an initial benefit of

Dalmane®

(flurazepam HCl)

proved by a 22-night clinical study of insomnia patients in the sleep research laboratory and at home[1]

Three insomnia patients selected for difficulty falling asleep were administered Dalmane (flurazepam HCl) 30 mg for 14 consecutive nights. Placebo was given for four nights prior to and four nights after Dalmane. Physiologic tracings on Dalmane nights 1-3 showed sleep induction time averaged 13.90 minutes; on Dalmane nights 12-14, 18.80 minutes. Combined average for the 6 monitored drug nights was 16.35 minutes.[1]



confirmed by clinical studies in four geographically separated sleep research laboratories[2-5]

Using a 14-night protocol involving eight insomniac and eight normal subjects, four studies confirmed the sleep-inducing effectiveness of Dalmane (flurazepam HCl) and the reproducibility of this response. On average, one 30-mg capsule induced sleep within 17 minutes. In all these studies, Dalmane induced sleep rapidly, reduced nighttime awakenings, and provided 7 to 8 hours of sleep without repeating dosage[2-5]

Dalmane (flurazepam HCl) induces and maintains sleep, with relative safety

Dalmane is generally well tolerated; morning "hang-over" has been relatively infrequent. While dizziness, drowsiness, lightheadedness and the like have been noted most often, particularly in the elderly and debilitated, physicians should be aware of the possibility of more serious reactions, as noted below.

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

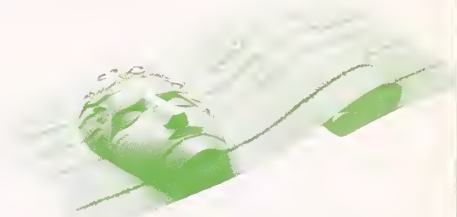
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.



when restful sleep is indicated

Dalmane®
(flurazepam HCl)

One 30-mg capsule *h.s.* — usual adult dosage (15 mg may suffice in some patients).
One 15-mg capsule *h.s.* — initial dosage for elderly or debilitated patients.

- induces sleep within 17 minutes, on average
- reduces nighttime awakenings
- sustains sleep 7 to 8 hours, on average, without repeating dosage

REFERENCES: 1. Kales A, *et al*: *Arch Gen Psychiatry 23*:226-232, Sep 1970
2. Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington DC, May 3-7, 1971
3. Frost JD Jr: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
4. Vogel GW: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
5. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ

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efore prescribing, see complete prescribing formation in SK&F literature or *PDR* The llowing is a brief summary.

dications: Edema associated with congestive art failure, cirrhosis of the liver, the nephrotic ndrome; steroid-induced and idiopathic lema; edema resistant to other diuretic therapy. lso, mild to moderate hypertension.

ontraindications: Pre-existing elevated serum otassium. Hypersensitivity to either component. Continued use in progressive renal or epatic dysfunction or developing hyperkalemia.

arnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia evelops or dietary potassium intake is markedly npaired. Enteric-coated potassium salts may use small bowel stenosis with or without ceration. Hyperkalemia (>5.4 mEq/L) has een reported in 4% of patients under 60 years, 12% of patients over 60 years, and in less an 8% of patients overall. Rarely, cases have een associated with cardiac irregularities. **ccordingly, check serum potassium during erapy, particularly in patients with suspected confirmed renal insufficiency (e.g., elderly or abetics). If hyperkalemia develops, substitute thiazide alone. If spironolactone is used ncomitantly with 'Dyazide', check serum otassium frequently**—both can cause potassium tention and sometimes hyperkalemia. Two eaths have been reported in patients on such mbined therapy (in one, recommended osage was exceeded; in the other, serum electolytes were not properly monitored). Observe atients on 'Dyazide' regularly for possible ood dyscrasias, liver damage or other idiocncratic reactions. Blood dyscrasias have been ported in patients receiving Dyrenium iamterene, SK&F). Rarely, leukopenia, rombocytopenia, agranulocytosis, and aplastic nemia have been reported with the thiazides. atch for signs of impending coma in acutely cirrhotics. Thiazides are reported to cross the acental barrier and appear in breast milk. his may result in fetal or neonatal hyperbilibinemia, thrombocytopenia, altered carbodrate metabolism and possibly other adverse actions that have occurred in the adult. When ed during pregnancy or in women who might ar children, weigh potential benefits against ssible hazards to fetus.

ecautions: Do periodic serum electrolyte and JN determinations. Do periodic hematologic udies in cirrhotics with splenomegaly. Antipertensive effects may be enhanced in postmpathectomy patients. The following may cur: hyperuricemia and gout, reversible trogen retention, descreasing alkali reserve th possible metabolic acidosis, hyperglycemia d glycosuria (diabetic insulin requirements ay be altered), digitalis intoxication (in pokalemia). Use cautiously in surgical tients. Concomitant use with antihypertensive ents may result in an additive hypotensive ect.

dverse Reactions: Muscle cramps, weakness, zziness, headache, dry mouth; anaphylaxis; sh, urticaria, photosensitivity, purpura, other rmatological conditions; nausea and vomiting ay indicate electrolyte imbalance), diarrhea, nstipation, other gastrointestinal disturnces. Rarely, necrotizing vasculitis, paresesias, icterus, pancreatitis, and xanthopsia ve occurred with thiazides alone.

pplied: Bottles and Single Unit Packages of 0 capsules.

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KEEP THE HYPERTENSIVE PATIENT ON THERAPY KEEP THERAPY SIMPLE WITH

DYAZIDE®

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Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

No potassium supplements
No special K^+ rich diets
Just 'Dyazide' once daily or twice daily

Studies have demonstrated that two prime reasons patients drop out of hypertensive therapy are: (1) the patient failed to understand directions, and (2) the regimen was overly complicated.* Dosage is simple with 'Dyazide', easily understood, once or twice daily, depending on response. There's no need to complicate the regimen with potassium supplements or unwieldy potassium-rich diets.

*E.D. Freis: The Modern Management of Hypertension, V.A. Information Bulletin, 11-35.

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The Rx that says "Relax"

BUTISOL Sodium provides highly predictable sedative effect: minor dosage adjustments are usually all that's needed to produce the desired degree of sedation. (With 3 dosage forms and 4 strengths to make adjustments easy.)

BUTISOL Sodium offers prompt, smooth, relatively non-cumulative action: begins to work within 30 minutes...yet, because of its intermediate rate of metabolism, generally has neither a "roller-coaster" nor a "hangover" effect.

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These are four good reasons for prescribing BUTISOL Sodium for the many patients who need to have the pace set just a little slower. Its gentle daytime sedative action is often all that's needed to help the usually well-adjusted patient cope with temporary stress.

*Based on surveys of average daily prescription costs.

Butisol® SODIUM®
(SODIUM BUTABARBITAL)

Contraindications: Sensitivity or idiosyncracy to barbiturates; history of manifest or latent porphyria or marked liver impairment; respiratory disease with dyspnea or obstruction; history of addiction to sedative/hypnotic drugs; uncontrolled pain, to avoid because of possible excitement.
Precautions: Exercise caution in: moderate to severe hepatic disease; anticoagulant therapy, because of possible increased metabolism of coumarin anticoagulants; withdrawal in drug dependence or the taking of excessive doses over a long period, to avoid withdrawal symptoms; elderly or debilitated patients, to avoid possible marked excitement or depression; use with alcohol or other CNS depressants, because of combined effects.
Adverse Reactions: Slight hangover, drowsiness, lethargy, headache, skin eruptions, nausea and vomiting, hypersensitivity reactions (especially in those with asthma, urticaria, angioneurotic edema, or similar conditions).
Usual Adult Dosage: For daytime sedation, 15 mg. to 30 mg. t.i.d. or q.i.d. For hypnosis, 50 mg. to 100 mg.
Available as: Tablets, 15 mg., 30 mg., 50 mg., 100 mg.; Elixir, 30 mg. per 5 cc. (alcohol 7%). BUTICAPS® [Capsules BUTISOL SODIUM (sodium butabarbital)] 15 mg., 30 mg., 50 mg., 100 mg.

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Breast self-examination:

KEY ROLE OF THE PHYSICIAN

item:	**Breast cancer is a major concern of American women, according to a recent Gallup study conducted for the American Cancer Society.**
item:	**Although aware that early discovery improves the chances of cure, and that BSE can lead to early discovery, *fewer than 1 in 5* women practice BSE, and *only half* have an annual breast examination by a physician.**
item:	**Only 35% of all women polled reported that a *physician* had ever raised the subject of breast self-examination, and only 24% had received instruction from the physician on how to do it. Even among women who regularly see a gynecologist, only 34% had been instructed on BSE.**
item:	***But,* among women who received personal instruction from their physicians, the overwhelming majority *(92%)* practiced BSE during the preceding year.**

The Gallup study revealed that, far more important than increasing awareness of breast self-examination, is the problem of inducing women to practice it regularly. The physician plays a key role in this—by teaching women the correct technique, and instilling in them the confidence that will assure their continued practice of BSE.

The American Cancer Society gives major emphasis to breast cancer through research and a vast array of public educational materials, designed to give women life-saving information about the disease. Our latest approach is via a pioneering television film starring Jennifer O'Neill, "Breast Cancer: Where We Are." Where we *will* be in a few years will certainly hinge on our joint efforts.

American Cancer Society®

WEST VIRGINIA DIVISION, INC.

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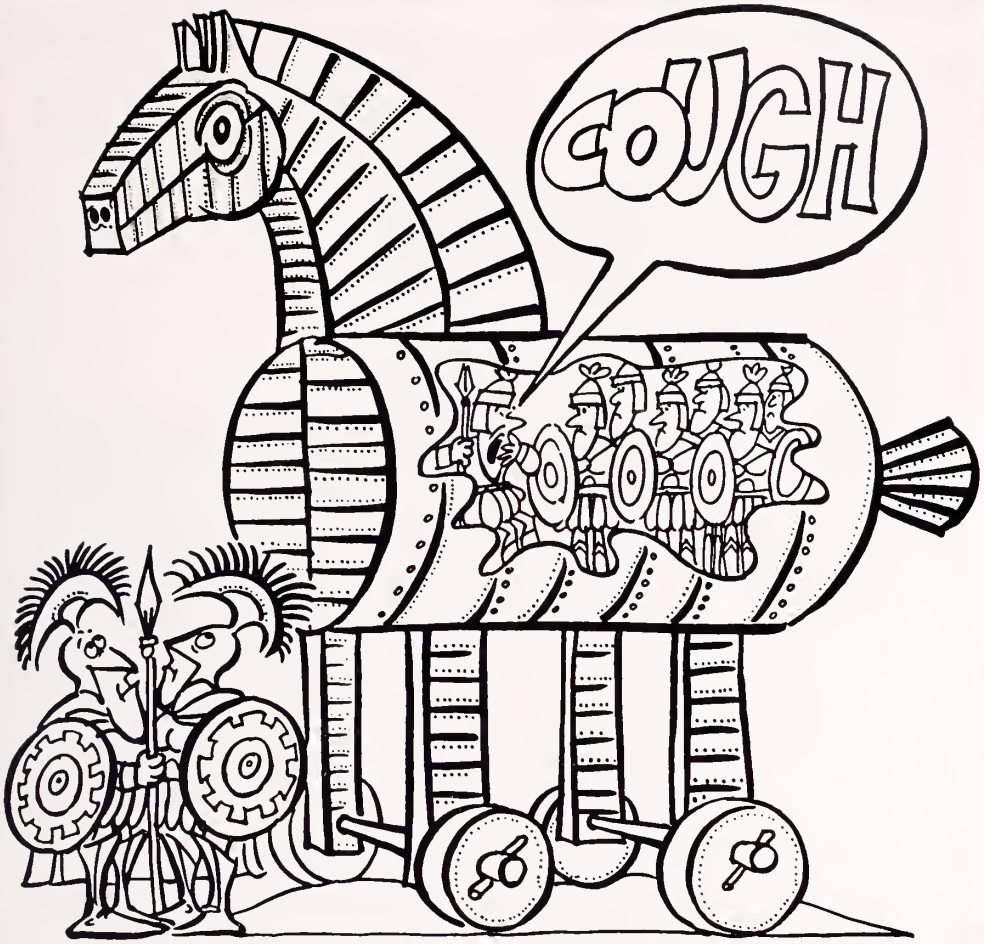
Charleston, West Virginia



When a cough spoils your patient's day...

Triaminic® Expectorant

Each teaspoonful (5 ml.) contains:

Triaminic, 25 mg. (phenylpropanolamine hydrochloride, 12.5 mg.; pheniramine maleate, 6.25 mg.; pyrilamine maleate, 6.25 mg.); glyceryl guaiacolate, 100 mg.; alcohol, 5%.

Available in 8-oz. Family Size and 4-oz.
No Rx needed—recommend over the phone.

The Adult Expectorant that is great for kids, too.

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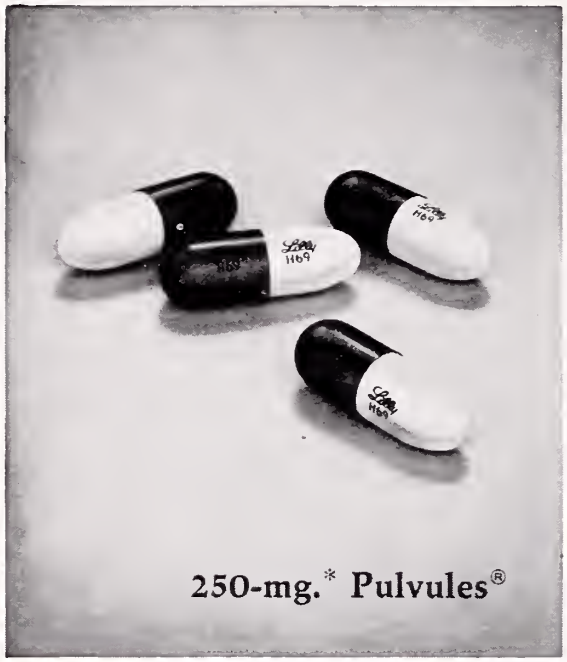
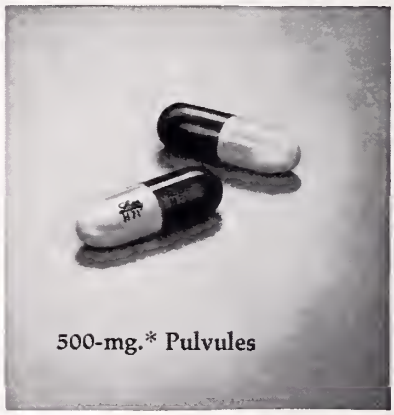
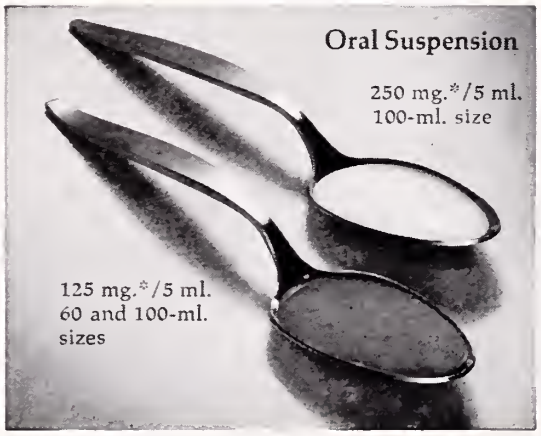
Keflex®
cephalexin monohydrate

it makes sense







*Equivalent to cephalexin.

Additional information available to the profession on request.

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The West Virginia Medical Journal

Vol. 70, No. 10 October, 1974

'The Thomas L. Harris Address'

(1974)

Hon. Robert C. Byrd*

It is a pleasure for me to be with you in one of West Virginia's most renowned showplaces. If I were a doctor, I would imagine that to be the resident physician at The Greenbrier Hotel would be a most pleasant professional assignment. I would not expect to end up a wealthy man, but I might well become the golf champion of the American Medical Association.

As I look around this distinguished gathering of West Virginia's men and women of medicine, I am reminded of four lines written by an anonymous poet—very possibly a doctor—sometime in the 19th century:

"Three faces wears the doctor;
when first sought—
An angel's; and a god's, the
cure half-wrought;
But when, the cure complete,
he seeks his fee,
The Devil looks less terrible
than he."

Well, I see no one in this audience who even faintly resembles the Devil, so I can only conclude that the physicians in West Virginia practice for no fees.

These remarks, I understand, are dedicated to the memory of Dr. Thomas L. Harris of Parkersburg, who was a man of much more than high professional competence. He was also a man of infinite human compassion, and he devoted much of his life toward unselfish service, above and beyond the call of duty. When Doctor Harris recited the Physician's Oath, perhaps he read further into the philosophy of Hippocrates. Perhaps he also read Hippocrates' "Precepts" in which it is written: "In all abundance there is lack."

And perhaps it was that realization that inspired Tom Harris to give so much of himself in order to alleviate the suffering that he saw all around him.

There are few professions in which more opportunity is given for selfless service than in the practice of medicine. Though the days are gone when the venerable general practitioner

Hon. Robert C. Byrd

*Presented by the Hon. Robert C. Byrd, United States Senator from West Virginia and Majority Whip of the Senate, during the 107th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 22, 1974.

drove his horse and buggy through sleet and snow and the dark of night on errands of medical mercy, instances still abound where the doctor emulates his earlier counterpart in the modern context of healing. The image is not quite so romantic, but the services performed are just as important.

The highly regarded School of Medicine at West Virginia University owes much to Doctor Harris' devoted attention to its founding and to its staffing, and to his continued interest in the School's progress.

The West Virginia State Medical Association never had a more enthusiastic member than Doctor Harris. His enthusiasm for the Association and his deep commitment to its value for West Virginia's physicians were proved by his bequest to the Association in his will, to be devoted to the furtherance of the State Medical Association as a valuable facet of medical practice in West Virginia.

The decision of the Executive Committee that the Keynote Address at the Association's Annual Convention shall henceforth be known as "The Thomas L. Harris Address" ensures that Doctor Harris' name will be enshrined, as it should be, as long as the West Virginia State Medical Association shall survive.

I am aware that, traditionally, the keynote speaker should deliver an address that sets the tone for subsequent deliberations and actions for the duration of the gathering. In my case, however, I could not presume to present a discourse on medical science or discuss the professional technicalities with which this distinguished group will doubtless be concerned.

I propose, therefore, to think of you today, not so much as physicians, but as Americans with a keen interest in the affairs of the nation, and with a genuine devotion to its future well being.

Physicians and Public Affairs

Over the years I have found that doctors, as busy as most of you are, are intensely interested in public affairs and are deeply concerned about our government and our country. I would, therefore, like to discuss with you some thoughts about the recent events through which our country has passed.

For the first time in our history an American President has resigned his office, and a Vice President who was not elected to office has succeeded him; and we have heard from many sources that our system does, indeed, work. The fact that we have a new President, and that the government has continued to function, has widely been heralded as conclusive proof of the soundness of the concepts upon which the founding fathers and the framers of our Constitution built.

We have all read and heard the statements of satisfaction that even in the hour of our national travail and crisis, our system worked. Much has been made of the fact that Republican members of the House Judiciary Committee, and conservative Southern Democrats who might have been expected to be sympathetic to President Nixon, did indeed vote for the impeachment articles.

The Constitutional System

The 8 to 0 decision by the Justices of the Supreme Court upholding the Special Prosecutor's subpoena of the White House tapes is also rightly cited as a constitutional strength.

I believe in our constitutional system; but I suggest that any euphoria may be a little premature. I think it is not amiss for us to take another look, to ask some questions, and to face some hard realities.

There is no doubt that the men who met in Philadelphia nearly 200 years ago gave us a remarkable and enduring document in the Constitution they drafted. Considering the times and circumstances in which *they* lived, and the vastly different and more complicated times and circumstances in which *we* live, it is astonishing that we can still carry on the affairs of government under our original charter.

That we *are* able to do so, I believe, is due, in great measure, to the fact that the men who devised the Constitution trusted no one with unchecked power. They understood that power corrupts and that absolute power corrupts absolutely. That is why we have three equal and coordinate branches of government, each acting as a check and a balance against the other. Based upon that concept, our system has worked remarkably well.

But let us not forget that the United States Constitution has been amended 16 times—in addition to the original 10 amendments, adopted as the Bill of Rights—and that other amendments are constantly being proposed. And let us also not forget that many practices, governmental and political, have grown up and become a part of our system without having been sanctioned by the Constitution—the political party system, for example—while at the same time some institutions provided for in the Constitu-

tion, like the Electoral College, do not now really serve the purposes originally intended.

So, while we believe our Constitutional system to be firmly grounded in philosophy and concept, there is nothing heretical in raising questions about its practical operation in respect of inpeachment. Troubling questions in that connection remain in the aftermath of Watergate. Richard Nixon was not removed from the presidency by the process expressly provided for in the Constitution. Despite the enormously damaging evidence against him, his guilt or innocence has not yet been formally established—and there is no consensus about what to do now.

The fact also remains that our current President is a man who has never run for national office. When his Party last went to the people, less than two years ago, and asked the people to express their will in a national election, Gerald Ford was not even remotely considered for the Vice Presidency.

President Ford has himself now chosen the man to be his own Vice President, and we find ourselves—this honored and honorable representative democracy—in the position of having the two highest offices in the land occupied by men who have not been elected by the people in a national referendum.

This is not to say that President Ford and Vice President Designate Rockefeller—if he is confirmed by the Congress—will not be a successful team. It may well turn out that both will be most felicitous choices for the future well-being of the United States.

Watergate

Moreover, had it not been for two almost accidental occurrences, the offenses now known under the generic name of Watergate might never have come to light, and Mr. Nixon would almost surely still be in office. I refer, of course, to the fortuitous discovery in June 1972 of the piece of tape on the door that led police to the so-called "third rate burglary" at Democratic National Headquarters— an incredibly clumsy and stupid action—and to the totally unexpected disclosure last summer of the existence of the White House tapes.

Our Constitutional processes were working well before the existence of the incriminating tapes was known. But I doubt that those processes alone would have led us to the point we have now reached.

The burglars were caught, an election was held in which Mr. Nixon won by a landslide, and the burglars were tried and sentenced. But again, almost by chance, a judge wasn't satisfied; a newspaper began to dig; and a highly placed White House aide decided to talk—all of which was as unexpected as was the revelation by a witness before the Senate Watergate Committee that conversations in the Oval Office had been taped.

I believe that had Mr. Nixon remained as President, he would have been impeached by the House of Representatives. And I think it very likely that, on the basis of the mounting evidence, he probably would have been convicted by the Senate. But would the Judiciary Committee of the House have voted articles of impeachment, and would the House have impeached, and would the Senate have convicted had it not been for the damaging evidence provided by the White House tapes?

The impeachment process, we have discovered, is agonizingly slow, and it could have gone on for months longer, continuing to paralyze much of the Executive Branch. Moreover, there is no assurance that the President would have been removed from office, despite any proven abuse of power and the seeming obstruction of justice, had it not been for his own apparent self-incrimination as revealed by the tapes.

I do not come before you today to advocate changes in our constitutional system, but rather to raise questions which all of us should ponder. Ours is not a parliamentary form of government in which a leader can be forced out of office on the issue of no confidence, and there is much to be said for the fixed term of office.

Constitutional Machinery Adequate?

But in the increasingly complex and insecure world in which we live, are we sufficiently equipped to deal with the kind of crisis in leadership through which we have passed? Is our constitutional machinery adequate? Even the framers of the Constitution were troubled by the impeachment mechanism they had provided. The impeachment clause caused intense debate at the Constitutional Convention and during the ratification process, and I think we can now perceive the difficulties impeachment involves.

I do not believe the White House should provide a sanctuary for any kind of activity that is above and beyond the law; but I also do not believe that it should be possible to remove a President, or to force him from office, for any save the most serious and compelling of reasons. Political animosity or standing in the polls should have nothing whatsoever to do with it.

But in this age of instant communication—

and possible instant war—two or three or four years of incompetence or wrongdoing could be disastrous for our country. Ideally, the voters should elect as President only men of proven integrity and demonstrated ability; but, human frailty and our election processes being what they are, that is probably too much to expect.

The end product of Watergate, so far as impeachment is concerned, I believe, will be to make impeachment and removal from office of a future President—should the need arise—more difficult, regardless of what he might do, unless he commits outright and blatant crimes, or helpfully furnishes the evidence needed for his conviction—which I am convinced no President will ever do again by the tape recording of incriminating conversations.

The 1970's and 80's are far removed from the 1770's and 80's when our government and our system had their beginning. Then, it could take days for messages to travel from Boston or Savannah to Washington, and weeks for ships to cross the oceans. Impeachment may have been adequate in 18th century America—or in 14th century England. But, today we have seen what neglect and delay can do to our economy and to other fast-paced problems while impeachment procedures are underway.

Proposed Changes

Our system is not static. Much of its genius lies in the fact that improvements can be made through orderly change. Many improvements have been made, as constitutional amendments testify. What is needed now, in my judgment, is a re-examination of the impeachment process with the objective of improving and strengthening it. If it is possible to make the machinery less ponderous, it should be done.

There are proposals already in committees of Congress for different methods of dealing with a crisis in leadership and for removal of a President from office, if warranted—among them, suggestions for referendum or recall elections. I believe that study, and debate, and considerations of such proposals are very much in order by Congress and the American people. I don't say we should adopt such proposals, but they are worth study.

The legacy of Watergate and the manner of Mr. Nixon's departure from office will be with us to color American opinions and attitudes for years to come.

I applaud Gerald Ford's efforts to unite the country again and to get on with the business of the nation, and I support him in those efforts. But the forced resignation of Mr. Nixon and the difficult and unresolved question of his possible subsequent prosecution are deeply divisive issues. The first rush of relief that Watergate is behind us has been replaced by the sober realization that Watergate is, as yet, by no means altogether behind us, and that we now should face as well the question of the efficacy of the impeachment process.

Regard for Duty and Responsibility Needed

So, perhaps it is comforting to console ourselves, now that the danger has receded, with the rationalization that the system worked. But it is more important for the future that we stop taking the system for granted, and remain constantly and acutely aware that however strong our Nation's foundations may be, it is only prudent that they be kept in sound repair at all times—and improved where possible. It is at all times essential that we remind ourselves and those who govern us that the Constitution of the United States, while conferring upon all our citizens inalienable rights, also requires of our citizens and our leaders in government, a high regard for duty and responsibility.

Almost 150 years ago, the German philosopher, Hegel, wrote in his *Philosophy of History*:

"What experience and history teach is this—that people and governments have never learned anything from history, or acted on principles deduced from it."

Let it not be said that that cynical appraisal of man's capacity to learn is still applicable to this Republic just two years short of our Bicentennial.

Permanent Sterilization By The Laparoscopic Method At The Bluefield Sanitarium 1973*

T. Keith Edwards, M. D.

Doctor Georg Kelling, a surgeon of Dresden, Germany, demonstrated that the intra-abdominal organs of a dog could be visualized by inserting a cystoscope through the abdominal wall in 1901.[1] In 1910, Jacobaeus of Sweden was the first to apply this new procedure to human patients. It was he who coined the name laparoscopy.[2] The first use of the laparoscope in the United States was by Bernheim in 1911.[3] The concept of using pneumoperitoneum and Trendelenburg were added in 1912.[4] On May 3, 1937 Doctor Ruddock, from the Medical Department of the University of Southern California Medical School in Los Angeles, gave the Chairman's address to the general medical section of the California Medical Association. He reported 500 cases of peritoneoscopy and urged a more general acceptance of the procedure.[5]

However, it was not until fiber optics came into their own that the laparoscopic procedure was generally accepted in the field of medicine. Furthermore, when this procedure was applied to the field of gynecology and obstetrics it came into its own for several reasons. With the patient in a high Trendelenburg position the pelvic organs, which are securely attached in the pelvis, will remain easily visible while the more movable abdominal viscera drops away towards the diaphragm. Secondly, the sterilization procedure is one which is frequently requested in the field of obstetrics and gynecology and can be more easily performed through the laparoscope with less patient morbidity than by any other approach.

The Author

- **T. Keith Edwards, M. D., Member of the Staff, Department of Obstetrics and Gynecology, Bluefield Sanitarium, Bluefield, W. Va.**

This paper is to simply present the number of cases of permanent sterilizations performed at the Bluefield Sanitarium in 1973 by the laparoscopic method. There were 221 cases of permanent sterilization attempted by using the laparoscope. Of these, 120 were interim sterilizations, while 93 were post-partum sterilizations and eight were post-abortal sterilizations.

In the cases of the interim sterilizations the patients were placed in a dorsal ski position, a high Trendelenburg tilt to the table and an instrument was introduced into the endometrial cavity to help in moving the uterus. In the cases of post-partum sterilization the patient was placed in a dorsal supine position, a moderately high Trendelenburg position and no instrument was needed in the endometrial cavity for manipulation of the uterus.

Table 1 gives the average parity, age and the

*Presented before the regular monthly meeting of the Mercer County Medical Society in Princeton on March 18, 1974.

TABLE 1

PARITY		AGE		AGE X PARITY	
Zero	1	19	1	<50	21
1	11	20-24	33	50-75	50
2	46	25-29	68	76-100	53
3	68	30-34	61	101-125	42
4	40	35-39	43	125+	55
5+	55	40+	15		
	221		221		221

TABLE 2

Summary of Complications:		Untoward Occurrences Not Directly Related to Procedure: 2½%	
Pomeroy's done	6 = <3%	Sub-involution-D. & C.	1
Untoward Occurrences	5 = <2½%	6 Weeks Later P.I.D.	1
		Typhoid Fever	1
Salpingitis	1	Endometritis	1
Infected Wounds	2	Cervical Biopsy-bleeding	1
Sore Throat	1		

product of age multiplied by parity for this group of patients. It may be noted that the age range is from 19 years to in the 40's; and, therefore, there were other indications besides simple age and parity. Seven of these patients had diabetes and some of these patients had poor obstetrical histories which frequently accompany diabetes. Four of the patients had Rh sensitization. Two were severely mentally retarded and in one case there was a history of familial mental retardation. One patient had a cardiac condition which would have necessitated termination of pregnancy had it occurred. In four cases there was moderate to marked hypertensive cardiovascular disease. Three cases had varicosities and in one case there had been a thrombophlebitis during the last pregnancy which required hospitalization. In three instances the patients had epilepsy and in one case a neurosurgical colleague had referred the patient because of a contraindication of either pregnancy or the use of birth control pills.

In six instances the planned procedure could not be carried out, and Pomeroy sterilization was performed. In two of these cases the CO_2 gas instilled into the subcutaneous tissues. Both of these cases were moderately obese patients and the verres needle had simply not been introduced deep enough to enter the peritoneal cavity. One of these patients is included in the table marked complications as an infected wound. In two instances the verres needle was introduced into the greater omental sac and this was distended with gas so that when the laparoscope was introduced into the abdominal cavity a membrane of omental sac was surrounding the end of the laparoscope and the pelvic organs could not be visualized. In two cases visualization proved to be extremely difficult; one of these was an interim case that had adhesions hiding the cornual portion of one tube, the other was a post-partum case in which the tube could not be mobilized from behind the large post-partum uterus.

Table 2 gives a summary of complications of the procedure including untoward occurrences not directly related to the procedure. In five cases there were complications directly related to the procedure. One patient developed an acute salpingitis with a temperature spike to 103 degrees immediately following the procedure. Two patients developed infected wounds of the abdominal site. One of these has been mentioned above, and the other suffered slight cauterization of the skin at the site of the operating trocar. One patient developed a sore throat and evidence of an upper respiratory infection following the general endotracheal anesthesia. This gave a complication rate of 2.5 per cent for untoward occurrences directly related to the procedure.

In addition to these complications there were five cases of untoward occurrences that were not directly related to the sterilization procedure. In one case, which was done post-partum, there was subinvolution of the uterus and the patient had to return for a D. & C. Six weeks following sterilization one patient returned with a diagnosis of pelvic inflammatory disease which responded to conservative therapy with antibiotics. One patient, following delivery and post-partum laparoscopic sterilization, was returned to the hospital with a high fever, signs of abdominal disturbance and hallucinations. Of course the admitting diagnosis included the possibility of accidental cauterization of the bowel. However, when the patient was completely worked up it was found that she had typhoid fever. This case was reported to the county health department and four more cases of typhoid fever were found in families who were using the same water supply. One patient developed an endometritis: this was a

post-partum case and no instruments were introduced into the endometrial cavity at the time of sterilization. One patient, who had evidence of squamous dysplasia on her pap smear, had a cervical biopsy performed at the same time as her interim sterilization. She had to return to the hospital approximately five days later because of post operative cervical bleeding. Including these cases we have a complication rate of 5 per cent for the year 1973 roughly divided in half between complications directly related to the sterilization procedure and complications that were unrelated to the sterilization procedure.

Summary and Comment

Two hundred and twenty-one cases of permanent sterilization attempted by the laparoscopic method at a small community hospital have been presented. In three per cent of the cases Pomeroy procedures were necessary. An overall complication rate of five per cent is noted. Because of the simplicity of this procedure and the opportunity to perform it frequently, because of patients requesting permanent sterilization, it is felt that gynecologists should be able to undertake this procedure in a small community hospital with substantial benefit to the community and a low risk of complications.

A list of references may be obtained by writing The Journal.

Athlete's Foot

The term "athlete's foot" was coined by an advertising man in the early 1930's to promote a patent remedy for fungus infections of the feet. The popular term is a misnomer, says the American Medical Association. You don't have to be an athlete to have a fungus infection of the feet. Anyone can have it.

Some people are more susceptible than others. A man may have the ailment for years and his wife will remain free of it. Doctors know that most of the efforts to prevent athlete's foot — chlorine foot baths at the swimming pool, disposable slippers, boiling of socks and treatment of shoes — are not helpful. Athlete's foot is almost never "picked up."

The most common form of athlete's foot is that which causes redness, cracks in the skin, itching and burning of the feet, particularly between the toes. The same fungus can cause blister eruptions of the soles of the feet.

Prevention requires that the skin of the feet, and most particularly between the toes, be kept cool and dry. When successfully done, this is more effective than the use of medicated powders, lotions, creams or ointments. Relief may be obtained by simple and bland substances, but a specific approach to treatment will often require the attention of a specialist with laboratory facilities for confirmation. Treatment should be aimed at the type of fungus causing the infection. Self medication may encourage complications and prolong discomfort and disability.

Warm, moist skin encourages the growth of all types of fungi. It is difficult to eliminate the fungi entirely, but their ill effects can be kept under control by keeping the feet cool and dry.

Familial Polyposis and Pituitary Chromophobe Adenoma

Philip P. Metzger, Albert S. Klainer, M. D.; R. Brooks Gainer, M. D., and William M. Chadduck, M. D.

FAMILIAL polyposis is an uncommon disease entity, one type of which has been described previously to have some association with endocrine adenomatosis.[1-6] The purpose of this report is to describe a case of a 22-year-old white female with familial polyposis and an associated pituitary chromophobe adenoma. To the best of our knowledge, such an association is unique, with the exception that Turcot, Despres and St. Pierre[7] described a brother and sister with multiple polyposis of the large intestine and central nervous system tumors: one had a medulloblastoma of the spinal cord, and the other a frontal lobe glioblastoma and an associated chromophobe adenoma of the pituitary gland.

The Authors

- **Philip P. Metzger (Fourth Year Medical Student); Albert S. Klainer, M. D.; R. Brooks Gainer, M. D.; and William M. Chadduck, M. D., Division of Infectious Diseases, Department of Medicine and the Division of Neurosurgery, Department of Surgery, West Virginia University Medical Center, Morgantown.**

Case Report

S. G. (W. V. U. No. 251336), a 22-year-old girl, was admitted to West Virginia University Medical Center on September 7, 1972 with a diagnosis of pituitary tumor presenting first as periods of amenorrhea—each lasting four to five months. Radiographs of the skull showed an enlarged pituitary fossa (Figure 1) which precipitated appropriate neuro-endocrinologic visual system examinations. At the time of admission she had had generalized headaches and intermittent blurred vision with progressive drooping of the left eyelid of approximately five months' duration. Ophthalmologic examination revealed a left third nerve palsy, normal visual fields, and a slight refractive error with visual acuity correctable to 20/20 bilaterally. The patient was known for at least two and a half years to have had asymptomatic familial polyposis diagnosed by proctosigmoidoscopic examination and barium enema which revealed multiple polyps of the large intestine (Figure 2A). Because of the possibility of a metastatic lesion involving the pituitary fossa, she was referred to the West Virginia University Medical Center for further diagnostic studies.

The patient's family history is significant in that her brother and mother are known to have familial polyposis diagnosed by proctosigmoidoscopic examinations and barium enemas (Figure 2B). Evidence of familial polyposis has not been discovered in other family members. No members of the family have been shown to have demonstrable pituitary or other endocrine disease.

On physical exam, the patient was a well-developed, slightly over-weight female. The left pupil was widely dilated and unreactive to light. The left globe was externally deviated, and there was marked ptosis with a suggestion of proptosis. There were no cranial, orbital or facial bruits. The remainder of the cranial nerves were intact. Motor, sensory, reflex and cerebellar testing were normal; and there were no pathological reflexes. There were no obvious changes in the hair or skin to suggest hypopituitarism, and the remainder of the physical examination was normal.

Laboratory data included a normal hemogram (hemoglobin 12.9 gm; hematocrit 39.4 per cent; leukocyte count 6,100; and red blood cell count 4.33 x 10^6). Urinalysis was normal. The serology was non-reactive. Serum electrolytes (chloride 103 meq/1; CO_2 content 26 meq/1; potassium 3.7 meq/1; sodium 141 meq/1), blood urea nitrogen (13 mg. per cent), glucose (73 mg. per cent), calcium (9.6 mg. per cent), phosphorus (4.4 mg. per cent), and alkaline phosphatase (45 mu/ml) were normal. T-3 was 32.8 per cent, and T-4 was 4.0 ugm. per cent. Urinary 17-ketosteroids were 8.3 mg./24 hours, and 17-hydroxycorticosteroids were 5.6 mg./24 hours. Plasma LH levels were 6 M-IU/ml., and plasma FSH by radioimmunassay was 9 M-IU/ml. Cranial arteriography showed no aneurysm, vascular blush, or suprasellar mass. A pneumoencephalogram demonstrated no significant suprasellar extension. An attempt to obtain a cavernous sinus venogram was unsuccessful. Fol-

Figure 1. Roentgenograph of the skull of the patient (lateral view) showing enlargement and erosion of the sella turcica.

lowing evaluation of the endocrine and optic systems, a transsphenoidal biopsy of the tumor was performed. At the time of operation, the septum of the sphenoid sinus abutted against soft tissue rather than bone; there was no bony anterior wall of the sella turcica. Definite inferior, lateral and anterior extension of the tumor were visible; however, the tumor did not break through the dura. After biopsy and partial removal of the tumor, the sphenoid sinus was packed with fat; and an acrylic plate was placed over the opening in the sphenoid sinus. The diagnosis of chromophobe adenoma of the pituitary gland was confirmed by histologic examination (Figure 3). She received cobalt irradiation of the tumor post-operatively and, interestingly, had her first menstrual period in 14 months midway through the radiation therapy. She has remained in good health since her operation and has continued to have regular menstrual periods.

Comments

Familial polyposis is transmitted as an autosomal Mendelian dominant trait involving both sexes and manifested by multiple polyps in the large intestine from the ileocecal junction to the anus. Other terms applied to this entity are familial adenomatosis, multiple adenomas, hereditary multiple polyps or papillomas. Theoretically, half of the offspring of a patient harboring the disease are affected, regardless of the sex of the parent or offspring. Approximately half of the patients found to have familial polyposis give a definite history for inheritance.[8]

McKusick[4] has subdivided intestinal polyposis into six genetically discrete variations: (1) familial polyposis of the colon;[9] (2) occasional discrete polyps of the colon and rectum;[10] (3) Peutz-Jeghers syndrome (generalized intestinal

2A

2B

Figure 2A. Barium enema of the patient showing multiple polyposis of the colon. (Figure 2B) Barium enema of the patient's brother showing multiple polyposis of the colon.

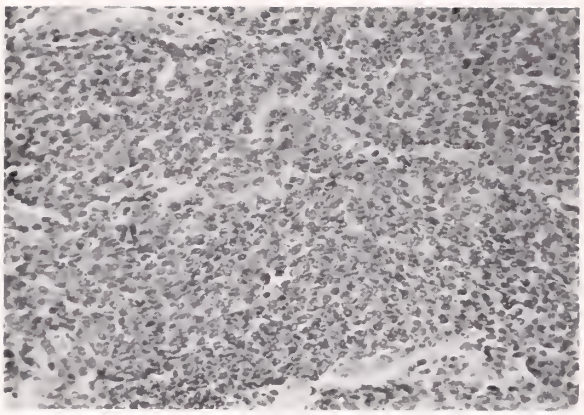

Figure 3. Photomicrograph (x 1000) of biopsy material obtained from the patient reported showing a typical chromophobe adenoma of the pituitary gland.

polyposis with melanin spots of the buccal mucosa, lips, and digits);[11] (4) Gardner's syndrome (colonic polyposis with osteomata, fibromata, and sebaceous cysts);[12] (5) Turcot syndrome (colonic polyposis and brain tumor);[7] and (6) multiple endocrine adenomatosis embracing Zollinger Ellison syndrome (colonic polyposis and associated endocrine adenomas).[13]

Only a single previous case of McKusick Type 6 familial polyposis has been described by Wermer and Schlager.[5] McKusick,[4] through a personal communication with Doctor Wermer, relates that this 66-year-old man died following subtotal gastrectomy for bleeding gastric ulcers. Autopsy revealed multiple polyps of the large intestine and adenomas of the pancreas and left adrenal gland.

Underdahl,[14] in his report on eight patients with multiple endocrine adenomas, describes two cases with diffuse gastric polyps (Menentrier's Disease), another gastric entity associated with Type 6 syndrome complex.

The patient in this study had a pituitary chromophobe adenoma associated with familial polyposis and most closely represents the Type 6 classification of McKusick (colonic polyposis with associated endrocrine adenomas). The inheritance in this family appears to be a Mendelian dominant type. We suggest that familial polyposis can be associated with a pituitary chromophobe adenoma resembling the Type 6 classification of McKusick and may represent a dual genetically inherited complex.

A list of references may be obtained by writing The Journal.

Cobra Venom Used Against Heart Attacks

PRELIMINARY studies by a Harvard team have shown that cobra venom factor (CVF) has markedly reduced the amount of dead tissue and the size of that necrotic area after heart attack in which the flow of blood to a portion of the heart wall is obstructed.

Dr. Peter R. Maroka, Assistant Professor of Medicine at Harvard Medical School, says that recent observations show the complement system is important in mediating nonspecific injury to tissues following this type of heart attack. Since CVF has anticomplementary activity, it is conceivable that CVF treatment would result in less tissue damage following acute coronary occlusion. In 15 anesthetized laboratory dogs, occlusion of the left anterior descending artery was performed. Results showed that in over half of the dogs, normal histology was exhibited showing protection of tissues brought about by CVF injections.

Further investigation is needed to confirm these test results and to show the procedure to be without risk. The National Society for Medical Research supports this research because it could have application in patients who have undergone an acute myocardial infarction, thereby reducing damage to heart tissue.

Renal Neoplasms in Children

Stanley J. Kandzari, M. D.; Susan L. Hill, M. D.; and D. Franklin Milam, M. D.

The diagnosis and management of renal neoplasms is a rare but persistent problem in the practice of pediatrics. Wilms' tumor is one of the most common intra-abdominal neoplasms in children. Benign tumors, on the other hand, are quite rare in this age group, and good reviews are few.

Renal lesions cause one-half of the abdominal masses of surgical importance in the young, and, of these, primary tumors comprise 20 to 30 per cent. Renal tumors cause 0.7 per cent of all deaths and eight per cent of the deaths due to cancer in children under 12 years of age.[1]

This paper is a report of our experience with pediatric renal tumors in the past 13 years at West Virginia University Hospital and a review of the literature on all solid parenchymal primary tumors in this age group.

Benign Tumors

Three to six per cent of all solid renal tumors in infants are benign.[1] In all large benign tumors, the incidence in females is twice that in males.[3] Benign tumors may arise from the renal capsule, perirenal tissue, or renal parenchyma. The mesenchymal forms are considered to represent developmental disorders arising from the original nephrogenic blastema. Benign tumors which are a mixture of various tissues of mesodermal origin are referred to as hamartomas.[2]

Symptoms of benign neoplasms are usually due only to their size, the most common presenting problem being that of a mass in the abdomen. They may attain such size as to obstruct abdominal vessels or the bowel, or to interfere with renal function. The hemangiomas often present with gross hematuria with the passage of large clots. The diagnosis is established by ruling out the malignant causes of renal mass. All tumors in the kidney parenchyma will cause distortion and displacement of the calyceal system on pyelogram, and angiography will then be conclusive.

The types of benign renal tumors which have been reported in children will be discussed.

Adenoma

Renal adenomas, which are a subject of controversy in regard to their potential for malignant change, have been reported in at least eight children.[4,5] These tumors may be tubular, papillary or alveolar in pattern. They may be single or multiple in one or both kidneys. When present as multiple adenomatous cysts associated with pancreatic cysts, hemangiomas of the retina and central nervous system, this is known as Lindau's disease.[6]

The Authors

- **Stanley J. Kandzari, M. D.; Susan L. Hill, M. D.; and D. Franklin Milam, M. D.; Department of Surgery, Division of Urology, West Virginia University Medical Center, Morgantown.**

Angioma

There has been only one lymphangioma reported in a child. It was a large multilocular cystic tumor which was benign.[7]

Hemangiomas are much more common. They are usually small and the cavernous type is the most common. They are often not palpable because of their small size and they may present with hematuria. Twenty-seven cases have been reported in the literature.[8]

Fibroma

This is a fairly common benign renal neoplasm in children. Fraser[9] reported one of nine kilograms but most are quite small. They are encapsulated and may contain areas of cystic degeneration and calcification. They may develop from the renal capsule, smooth muscle rests in the embryonic kidney, the walls of vessels, or the renal pelvis.

Lipoma

These are sharply circumscribed masses full of mature fat cells with minimal stroma. There are no reports of renal lipomas in children.[10]

Angiomyolipomas

These are the most common benign renal tumors found in children. They are commonly associated with tuberous sclerosis when found in this age group. The diagnosis should be suspected from the coincidence of the renal lesion, particularly when bilateral, with mental deficiency, epilepsy and the facial rash. Treatment should always be conservative unless there is evidence of a rapidly expanding mass.[11]

Cholesteatoma

This is a rare benign form of epithelial metaplasia reported only once in a child.[12] This child had a palpable mass and supracalyceal calcification on the intravenous pyelogram. The origin of the tumor was the pyelocalyceal epithelium and the pathogenesis was thought to be squamous metaplasia as the result of obstruction.

Teratoma

Teratoma usually arises in the retroperitoneal area rather than in the kidney, but a renal origin has been reported by McCurdy.[13] This tumor contains derivatives of all three germ layers.

Mesoblastic Nephroma

This is a congenital tumor which Bolande et al, in 1967, distinguished from a Wilms' tumor because of its benign cytology.[14] The primary clinical significance of this tumor is in its close histologic resemblance to Wilms' tumor. These tumors are characterized by a mixture of mesenchymal and epithelial elements. Bolande has reported that as many as 50 per cent of the renal tumors initially diagnosed as Wilms' tumor in children less than one year old proved to be congenital mesoblastic nephromas. Despite the non-encapsulated locally infiltrating growth pattern of this tumor, it is clinically benign. Proper histologic identification would eliminate the morbidity and mortality associated with inappropriate irradiation and chemotherapy.[10]

Malignant Tumors

Renal Cell Carcinoma — This tumor is the most common renal neoplasm in adults, but only about 55 cases have been reported in the pediatric age group.[15] It accounts for about 2 per cent of renal neoplasms in children. Histochemical studies reveal them to be derived from renal tubular epithelium and possibly from previously present adenomas. Treatment is nephrectomy and postoperative radiation should be employed.

Transitional cell carcinoma of the renal pelvis is another rarity in children and may be confused with the papillary forms of nephroblastoma.

Nephroblastoma

Nephroblastoma is the most common of all the tumors of the genito-urinary tract and comes second only to neuroblastoma as a cause of death from malignancy in childhood.[16] It may present at any age during childhood but the majority occur between the ages of 6 months and 3 years. Wilms' tumor is encountered in one in every 2,000-3,000 admissions to pediatric hospitals.[17]

The incidence of bilateral Wilms' tumor is greater than one would expect. Scott noted 33 bilateral cases in a comprehensive review of 906 cases of Wilms' tumor, an incidence of 3.6 per cent.[18]

The accepted etiology presently is that of a failure of normal development of the renal blastema which differentiates into all mesenchymal tissues.

Many congenital abnormalities have been associated with Wilms' tumors. One of the most comprehensive reviews is by Miller et al.[19] Some of the associated anomalies are aniridia, hemihypertrophy, hemangiomas, congenital heart defects, and various genitourinary anomalies.

An abnormal mass is the most common presenting feature and is present in 90 per cent of cases. Pain is the next most frequent symptom occurring in about one-third of reported cases. The tendency of this tumor to invade the venous drainage makes a strong rule against unnecessary palpation of the mass an important preoperative precaution. The very high incidence of pulmonary metastasis is related to this venous extension.

On intravenous pyelography the soft tissue mass enlarging the renal shadow is commonly seen and calcification occurs in 10 to 15 per cent of cases. It is unusual to find a completely non-functioning kidney in nephroblastoma. Very gross distortion of the pyelogram is the characteristic feature of nephroblastoma.

Surgery, radiotherapy and chemotherapy all have unquestionable value in the treatment of nephroblastoma. The relative rarity of the tumor in any one center had prevented a full assessment of the advantages of any particular regimen. Since the creation of the National Wilms' Tumor study, survival rates have risen from 20 per cent two-year survival three decades ago to 80 per cent within the last ten-year period.[20] This has been the result of collaborative efforts encompassing surgeons, pediatricians and radiotherapists. Prompt surgery, postoperative radiation therapy and the use of chemical anti-cancer agents have contributed to these good results. Both Vincristine and Actinomycin D have been shown to have anti-tumor activity.

Ten cases of Wilms' tumor have been diagnosed and treated at West Virginia University

Medical Center. The youngest child treated was five and one half months and the oldest 15 years. There were no cases of Wilms' tumor which met the qualifications for Group I. Four children had tumors in Group II, three children had tumors in Group III, and three children fell into Group IV of the National Wilms' Tumor Protocol. At the time of this publication, all patients were alive and well with no evidence of recurrent disease. The longest follow-up was 12 years in a patient in Group II and 11 years in a patient in Group IV.

Summary

The diagnosis and treatment of benign and malignant pediatric renal neoplasms has been reported. Benign tumors are quite rare in this age group whereas Wilms' tumor is one of the most common neoplasms in children. A review was made of the world literature on the subject plus our experience at West Virginia University Medical Center.

A list of references may be obtained by writing The Journal.

Manuscript Information

Manuscripts to be presented for publication in *The West Virginia Medical Journal* should be typewritten, triple-spaced, on one side only of firm (not onion skin or flimsy), standard letter sized (8 1/2 by 11 in.) white paper. Wide margins (at least 1 1/4 in. on left) should be left free of typing. On the first or title page should be shown the title of the article, the name (or names) of the author, and his degrees. Pages should be numbered consecutively, the page number being shown in the right upper corner along with the surname of the author.

Authors are requested to submit a carbon copy with the original or retain same in the event the manuscript is lost in transmittal.

Illustrations should be numbered and their approximate locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for cuts should be done in black (India) ink on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it. The author will bear the cost of all over two one-column halftone cuts.

All scientific material appearing in *The Journal* is reviewed by the Editorial Board. Manuscripts should be mailed to The Editor, West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

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THE PROGRAM again will offer a wide-ranging clinical and educational experience for the practicing physician. FRIDAY AFTERNOON, January 24, session on heart diseases; FRIDAY EVENING, presentations will include PSRO's and a session open to the public on the "problems of adolescents." A medically oriented program on problems of adolescents will be held SATURDAY MORNING, January 25 with these other scheduled subject areas to follow: SATURDAY AFTERNOON, cerebral vascular diseases and diabetes; SUNDAY MORNING, January 26, pulmonary disease in adolescents, cancer and "How to Avoid Malpractice."

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THE PROGRAM CO-CHAIRMEN again are Ralph H. Nestmann, M. D., and Joseph T. Skaggs, M. D., both of Charleston. Also on the Program Committee are William O. McMillan, Jr., M. D., of Charleston, and C. Carl Tully, M. D., of South Charleston.

THE REGISTRATION FEE of $15 for the entire conference will be charged all registrants except nurses, medical students, interns and residents. Advance registration is requested, and please make checks payable to "WEST VIRGINIA STATE MEDICAL ASSOCIATION."

ACCREDITATION: Attendance will be acceptable for Category 1 credit toward the Physician's Recognition Award of the American Medical Association; and the program also is expected to carry prescribed credit by the American Academy of Family Physicians.

OVERNIGHT ACCOMMODATIONS: Physicians should communicate directly with the reservation manager of the hotel or motor inn of their choice, with the conference headquarters hotel setting aside rooms for registrants.

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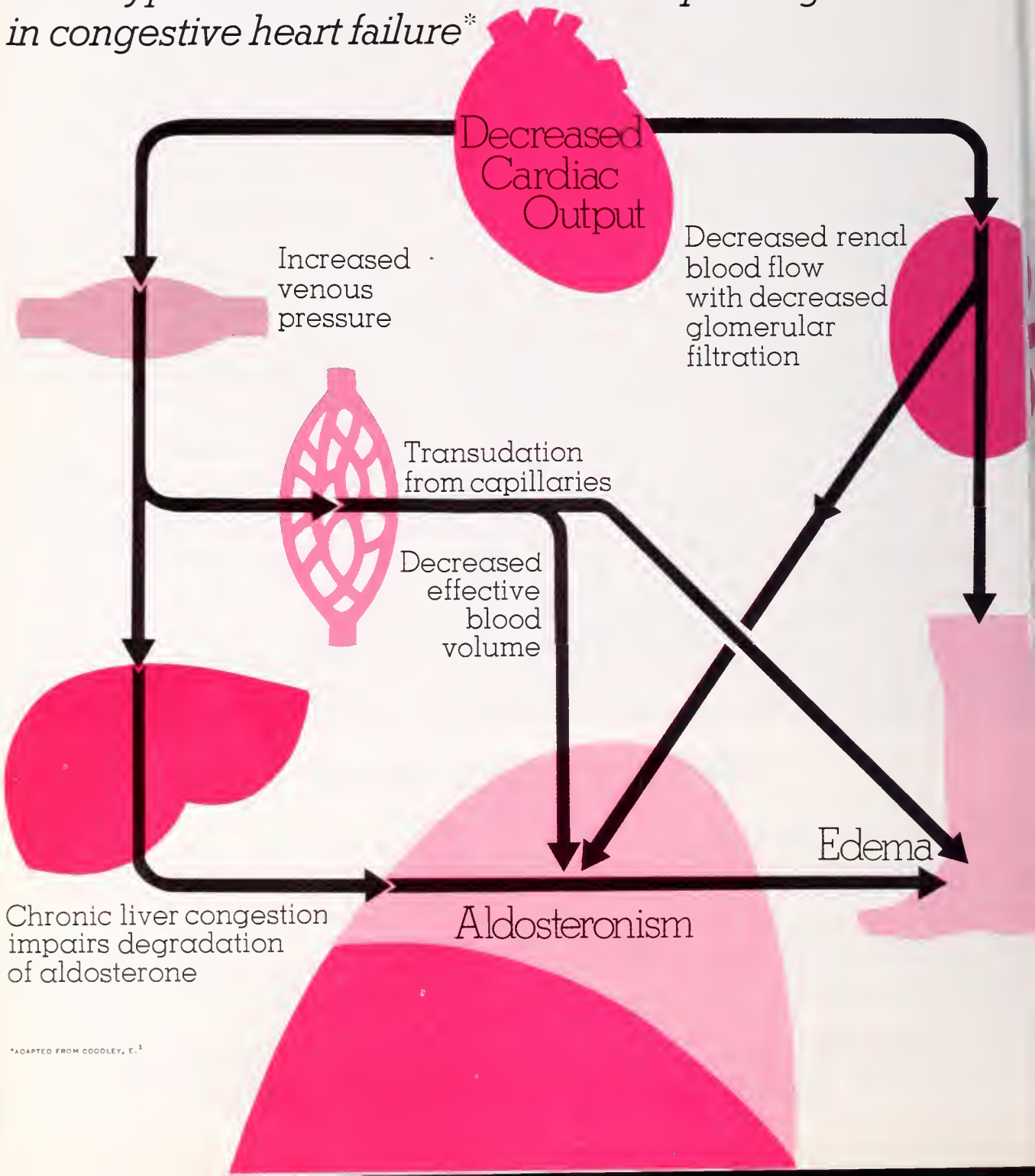

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- Avoids acute volume depletion and aldosterone rebound.[2]

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Warnings—Potassium supplementation may cause hyperkalemia and is not indicated unless a glucocorticoid is also given. Discontinue potassium supplementation if hyperkalemia develops. **Usage of any drug in women of childbearing age requires that the potential benefits of the drug be weighed against its possible hazards to the mother and fetus.**

Precautions—Patients should be checked carefully since electrolyte imbalance may occur. Although usually insignificant, hyperkalemia may be serious when renal impairment exists; deaths have occurred. Hyponatremia, manifested by dryness of the mouth, thirst, lethargy and drowsiness, together with a low serum sodium may be caused or aggravated, especially when Aldactone is combined with other diuretics. Elevation of BUN may occur, especially when pretreatment hyperazotemia exists. Mild acidosis may occur. Reduce the dosage of other antihypertensive drugs, particularly the ganglionic blocking agents, by at least 50 percent when adding Aldactone since it may potentiate their action.

Adverse Reactions—Drowsiness, lethargy, headache, diarrhea and other gastrointestinal symptoms, maculopapular or erythematous cutaneous eruptions, urticaria, mental confusion, drug fever, ataxia, gynecomastia, inability to achieve or maintain erection, mild androgenic effects, including hirsutism, irregular menses and deepening voice. Adverse reactions are infrequent and usually reversible.

Dosage and Administration—For **essential hypertension** in **adults** the daily dosage is 50 to 100 mg. in divided doses. Aldactone may be combined with a thiazide diuretic if necessary. Continue treatment for two weeks or longer since an adequate response may not occur sooner. Adjust subsequent dosage according to response of patient.

For edema, ascites or **effusions** in **adults** initial daily dosage is 100 mg. in divided doses. Continue medication for at least five days to determine diuretic response; add a thiazide or organic mercurial if adequate diuretic response has not occurred. Aldactone dosage should not be changed when other therapy is added. A daily dosage of Aldactone considerably greater than 75 mg. may be given if necessary.

A glucocorticoid, such as 15 to 20 mg. of prednisone daily, may be desirable for patients with extremely resistant edema which does not respond adequately to Aldactone and a conventional diuretic. Observe the usual precautions applicable to glucocorticoid therapy; supplemental potassium will usually be necessary. Such patients frequently have an associated hyponatremia—restriction of fluid intake to 1 liter per day or administration of mannitol or urea may be necessary (these measures are contraindicated in patients with uremia or severely impaired renal function). Mannitol is contraindicated in patients with congestive heart failure, and urea is contraindicated with a history or signs of hepatic coma unless the patient is receiving antibiotics orally to "sterilize" the gastrointestinal tract.

Glucocorticoids should probably be given first to patients with nephrosis since Aldactone, although useful for diuresis, will not directly affect the basic pathologic process.

For **children** the daily dosage should provide 1.5 mg. of Aldactone per pound of body weight.

References: 1. Coodley, E.: Consultant 12:106-107, 109, 111, 113, 115 (July) 1972. **2.** Thorn, G. W., and Louler, D. P.: Am. J. Med. 53:673-684 (Nov.) 1972.

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The Role of the Detail Man

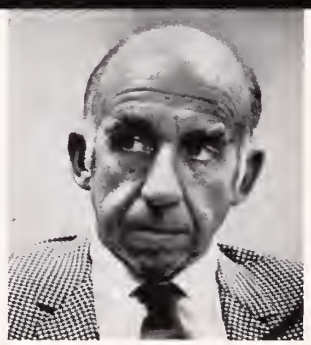
Opinion & Dialogue

Dr. Willard Gobbell
Family Physician
Encino, California

"I may be prejudiced, but I a very much in favor of the detail m n I meet. Most of them are knowled able about the drugs they promot and can be a great help in acquai ing me with new medication."

Family Physician's Perception

I think that most general practitioners in this area feel as I do about tne detail man. Over the years I have gotten to know most the men who visit me regularly ar they in turn have become aware o my particular interests and the na ture of my practice. They, therefore, limit their discussion as muc as possible to the areas of interes to me. Since I usually see the sam representative again in future visits, it is in his best interest to supply me with the most honest, factual, as well as up-to-date inforrnation about his products.



Dr. Jeremiah Stamler
Chairman
Department of Community Health and Preventive Medicine, and Dingman Professor of Cardiology
Northwestern University Medical School

"In the total picture of dealin with health problems in this count there is a potential for detail men to play a meaningful role."

The Positive Influence

My contact with representatives and salesmen of the pharmaceutical industry is the type of con tact that people in a medical cente research people, and academic people have and that's in all likelih on a somewhat different level from that of the practicing physician.

Let me touch on how I person ally perceive the role of the sales representative. These men reach large numbers of health professionals. Thus they could be—and at times actually are—disseminators of useful information. They could consistently serve a real educational function in their ability to discuss their products.

At present they do distribute printed material, brochures and pamphlets—some of it scientifically sound and therefore truly useful—as well as some excellent film produced by the pharmaceutical industry. When they function in thi

e a Source of Information?

Yes, with certain reservations. average sales representative a great fund of information ut the drug products he is re- nsible for. He is usually able to ver most questions fully and lligently. He can also supply ints of articles that contain a t deal of information. Here, I exercise some caution. I usu- accept most of the statements opinions that I find in the ers and studies which come n the larger teaching facilities. es without saying that a physi- n should also rely on other rces for his information on rmacology.

ning of Sales Representatives

Ideally, a candidate for the ition as a sales representative pharmaceutical company uld be a graduate pharmacist has a questioning mind. I don't k this is possible in every case, so it becomes the responsibility of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

---

acity they are indeed useful; ticularly in the fact that they seminate broadly based educa- al material and serve not just "pushers" of their drugs.

Other Side of the Coin

Obviously, the pharmaceuti- companies are not producing all material as a labor of love— y are in the business of selling ducts for profit. In this regard ambitious and improperly moti- ed sales representative can rt a negative influence on the cticing physician, both by pre- ting a one-sided picture of his duct, and by encouraging the ctitioner to depend too heavily drugs for his total therapy. In se ways, the salesman has often orted objective reality and lermined his potential role as an cator.

Industry Responsibility

Since the detail man must be nformation resource as well as presentative of his particular rmaceutical company, he uld be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—*i.e.*, the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that information must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

P·M·A

A message from . . .

The President

THE MELODIES LINGER ON!

THE 107th Annual Meeting of the West Virginia State Medical Association has come and gone—but the melodies linger on!

It was a great meeting for our Association: Dr. Malcolm C. Todd, President of the American Medical Association; Mrs. Liljestrand, President of the Woman's Auxiliary to the AMA; and Sen. Robert C. Byrd, the "Thomas L. Harris Lecturer," added great substance and dignity to our deliberations in the beautiful setting of The Greenbrier. Our leaders in the scientific sessions were stimulating and yet very practical—in subjects of high interest to the primary physician and specialist alike.

Combined "breakfast-section" meetings proved acceptable to most of us so that afternoons were freed for recreation, the savor of that great resort.

For the Gilmores, the reunion of our entire family was pure delight, and to include Bob and Marilyn Schilling in our family circle was a rare and genuine privilege.

Our gratitude goes to all who sacrificed so many hours to insure the success of our Annual Meeting. Now, a new year in our Association is at hand. We are refreshed, we are informed, and we must be about our raison d'etre: promoting the art and science of medicine, and the public health of West Virginia.

Bill Gilmore

WILLIAM E. GILMORE, M. D., *President*

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Editor
GEORGE F. EVANS, M. D.
122 South Sixth St.
Clarksburg, W. Va.

Managing Editor and
Business Manager
MR. WILLIAM H. LIVELY
Box 1031
Charleston, W. Va. 25324

Associate Editors:
VERNON E. DUCKWALL, M. D.
Elkins
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Charleston
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STEPHEN D. WARD, M. D.
Wheeling

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EDITORIALS

THE NEW PRESIDENT

As described somewhat sentimentally by Doctor Gilmore on the opposite page. the melodies do indeed linger on following the 1974 Annual Meeting held at The Greenbrier in late August. All those persons in attendance seemed to thoroughly enjoy and participate in the scientific, business and social activities carefully planned by a most capable group of physicians and members of the Auxiliary.

As mentioned in the closing sentences of Doctor Gilmore's message, however, all good things such as the delightful respite at The Greenbrier must come to an end. By this time we know our physician members are back at work looking after sick patients and trying to comprehend and cope with the myriad of obstacles which are being placed in their way daily by unrealistic bureaucratic rules and regulations.

Dr. William E. Gilmore is well aware of these demands which have been thrust upon members of the profession. More than 20 years in the active practice of his specialty of surgery and an active interest in the affairs of organized medicine have given him a good insight into how private practicing physicians must react in a positive manner.

There is no doubt the record will show next August that Doctor Gilmore provided strong leadership during his term as President of the Association.

A native of Wheeling and a graduate of West Virginia University, the Parkersburg surgeon has always been loyal to the State and its citizens—not only in his daily practice of medicine but in the many civic and community affairs in which he has given unselfishly of his time. A glance

William E. Gilmore, M. D., President

at a more complete biographical sketch published in the lead news article in this issue of *The Journal* will give you further information concerning his many activities along this line.

Doctor Gilmore and his wife, Maxine, are the parents of five wonderful children—one of whom, John, is a graduate of the West Virginia University School of Medicine and now in residency training in Denver, Colorado.

Now, we would like to commend a few persons responsible for the success of this year's Annual Meeting.

Dr. A. Thomas McCoy, the Immediate Past President, is again to be congratulated for a fine year of stewardship for the Association. He has already been recognized for the wonderful job he performed as well as for his visits to a majority of the component medical societies to carry the message of unity to the profession within West Virginia.

One accomplishment should not be forgotten. He and Dr. J. Hugh Wiley — the physician he named to serve as Program Chairman for the 1974 Annual Meeting — had the intestinal fortitude to make a big change in the format for this year's Convention. The most notable change in scheduling was the switch of meetings of sections and affiliated societies from the afternoon hours to the breakfast hour.

How well did they succeed? One interested observer made a nose count at each breakfast meeting and found that attendance was as good if not better than in previous years.

Evidently our physicians liked the idea of scheduling the popular scientific sessions during the pre-noon hour — while leaving them free to pursue their favorite form of recreational activity during the afternoons.

A tip of the hat to Doctors McCoy and Wiley and we've been informed by the 1975 Program Chairman that the same procedure will be followed at next year's Annual Meeting. We're sure Doctor McCoy and his close friend in Morgantown will not allow this successful undertaking to take the wind out of their sails. We expect to hear more from these two gentlemen.

Also, we would be remiss not to commend Dr. Worthy W. McKinney, who served faithfully as Chairman of the Council during a year that proved to be difficult — to say the least. It was his responsibility to keep the business before Council in order and he responded to the task in a beautiful manner.

It is doubtful if the Council had ever been called into session more often in one year and for as many varied reasons. There were instances when the discussions became heated and perhaps out of order. It is to Doctor McKinney's credit — and for the benefit of members of the Association — that he dealt with these matters sternly and rendered strong decisions in proper parliamentary fashion. We are all the better for his dedicated leadership.

We know our own members enjoy attending the Annual Meeting at The Greenbrier and are disappointed when they are unable to be there for various reasons. What about our invited speakers and honor guests? We'll quote from one typical letter received from a prominent physician who has appeared as a speaker at numerous medical meetings throughout the country and abroad:

". . . I wish to thank you and your colleagues for a genuinely fine time. The hospitality was first class all the way. I have attended more than a few State Medical Association meetings, and I would like to compliment the West Virginia State Medical Association on the good attendance at its scientific sessions. I went to most of your sessions on Thursday, Friday and Saturday and found them surprisingly well attended."

The headquarters office has received a number of other similar letters and, as usual, more than one guest said they planned to mark off our annual meetings on their calendars in the future whether invited officially or not. What else can we say.

See you at the Greenbrier next August!

CARBON MONOXIDE POISONING

Winter will soon be here and it is this season in which the majority of cases of carbon monoxide poisoning occur. Although during the past few years editorials have appeared in *The Journal* on the hazards of carbon monoxide poisoning it seems fitting to call attention again to the dangerous sequelae which may arise in the patient who survives the initial insult. Carbon monoxide poisoning is in most cases preventable and with proper education of the public cas practically be eliminated.

One of the most common causes of carbon monoxide poisoning is that of starting an automobile in a closed garage. This is utter folly and the public should be warned of its extreme danger. Other common causes are a leaky gas pipe in the home or a gas-burner which is not

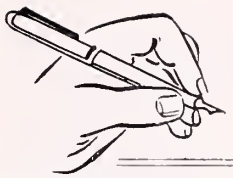
properly adjusted so that combustion of the gas is not complete; in some instances the vent is inadequate. All these causes can be eliminated if a little care is exercised.

The great danger of carbon monoxide poisoning is, of course, the after effects which it may produce. In severe cases the victim, who has been exposed to carbon monoxide, loses function of many of the cells in the cerebrum, that is, irreversible brain damage has been done, and the cells no longer are capable of functioning normally. The survival time of cerebral cells in oxygen want is much less than those cells in the medullary center or the spinal cord. Once the cerebral cells have been seriously injured, nothing can be done to remedy the damage. As a consequence, the patient leads a vegetative type of existence the remainder of his life. Truly a great tragedy.

In cases where minor damage has occurred the sequelae may be much less severe and only a small amount of cerebral damage occurs; for example, there may be only a blunting of the finer sensibilities. But even a slight amount of cerebral damage is a grave matter and if possible should by all means be prevented. The difficulty is that once the damage has occurred not much if anything can be done to alleviate it.

A patient who has been exposed to carbon monoxide poisoning needs immediate attention. He should be removed at once from the environment which produced the poisoning and allowed to breathe normal air. The carbon monoxide is gradually eliminated from the body. The patient should be allowed to breathe pure oxygen if available; this will hasten the elimination of carbon monoxide. A still more effective means is to supply oxygen at high pressure, that is, the use of hyperbaric oxygenation. This procedure not only causes the carbon monoxide to be eliminated more rapidly, but also combats the secondary hypoxia which may have developed as a result of brain swelling. It is appreciated that there are few, if any, places in the State in which an apparatus for administering hyperbaric oxygenation exists. It is to be hoped that eventually this will be remedied.

In sum, a patient who has been exposed to carbon monoxide, should receive immediate care so as to prevent permanent damage to cerebral cells; no expense or trouble should be spared. Furthermore, the public should be informed that carbon monoxide poisoning in nearly all cases is preventable.



Our Readers Speak

KUDOS FOR THE JOURNAL

I believe *The West Virginia Medical Journal* many times will find its way to many parts of our country and to different corners of the world.

Recently I had published in *The Journal* a case of Gaucher's Disease in a 32-year-native white female. I have received requests for reprints from Western Europe, Eastern Europe, Asia, South America, and different states of the Union.

To name a few, requests for reprints were received from the University of Louvain, Brussels, Belgium; University of Pecs, Pecs, Hungary; Research Institute, Wakayama Medical College, Wakayama, Japan; Institucion Mexicana De Asistencia, a la Ninez, Mexico; University of Missouri, Pittsburgh and Virginia, and from the Memorial Children's Hospital, Oklahoma City, Oklahoma.

I believe this information would be very gratifying to you and the other editors of *The West Virginia Medical Journal.*

Cordell A. De La Pena, M.D.
United Hospital Center, Inc.
Clarksburg, W. Va. 26301

* * * *

VD: LET'S CURB THIS SCOURGE!

The Bureau of Venereal Disease Control of the West Virginia State Department of Health is concerned about the alarming increase in venereal disease. Without the cooperation from physicians in private practice the control of the epidemic spread of venereal disease will be practically impossible. In 1973, 3,766 cases were recorded in West Virginia, a 33 per cent increase over 1972.

Although only 5 per cent of the population is in the 15-19 age bracket, this age group furnishes 36 per cent of the total reported cases. I want to call your attention to House Bill No. 622 passed in 1971 by the West Virginia Legislature giving permission not only to treat minors with venereal disease but minors who have come in contact with venereal disease. I quote:

"Notwithstanding any other provision of law, any licensed physician may examine, diagnose, and treat any minor who may have come in contact with a venereal disease or who is infected

(Continued on Page xxii)

GENERAL NEWS

Dr. William E. Gilmore Assumes Association Presidency

Dr. William E. Gilmore, a Parkersburg surgeon, was installed by the West Virginia State Medical Association as its President at the concluding session of the House of Delegates during the 107th Annual Meeting Saturday, August 24, at The Greenbrier in White Sulphur Springs.

The convention began with Council and House of Delegates sessions on Wednesday, August 21. Registration totaled 525 and included 288 physicians.

Doctor Gilmore was installed by Dr. A. Thomas McCoy of Charleston, the retiring President, who had delivered the traditional President's address a few minutes earlier. The text of the address will be published in the scientific section of the November issue of *The Journal.*

Doctor McCoy automatically became Chairman of the Council for the new Association year, succeeding Dr. Worthy W. McKinney of Beckley.

Other New Officers

Elevated to President Elect from Vice President was Dr. Jack Leckie, a Huntington family physician who will assume the Presidency at the 1975 meeting, also scheduled at The Greenbrier next August 20-23.

Dr. John J. Mahood of Bluefield was elected Vice President and Dr. Kenneth G. MacDonald of Charleston was re-elected to his 10th one-year term as Treasurer. Doctor Mahood is a dermatologist and Doctor MacDonald is a surgeon.

Dr. Richard E. Flood of Weirton was re-elected as a Delegate to the American Medical Association, with Dr. Harry S. Weeks, Jr., of Wheeling, re-elected as an Alternate Delegate.

Five new Council members were named with four other physicians re-elected to two-year terms. The new members elected are Drs. Lyle D. Vincent of Parkersburg, Walter E. Klingensmith of Beckley, Ray M. Kessel of Logan and David F. Bell, Jr., of Bluefield. There being no nominations from the floor, Doctor Gilmore, in accordance with the Association's By-Laws, has appointed Dr. L. Walter Fix of Martinsburg as Councilor for the Fourth District. Doctor Fix succeeds Dr. Robert R. Pittman, who was not eligible for reelection.

Reelected were Drs. Robert G. Janes of Fairmont, Harold N. Kagan of Huntington, L. H. Nefflen of Elkins and W. Alva Deardorff of Charleston.

In the left photo are the new officers installed by the State Medical Association at its Annual Meeting. Seated, from left, are Drs. Jack Leckie of Huntington, President Elect; William E. Gilmore, Parkersburg, President, and John J. Mahood, Bluefield, Vice President. Not shown is Kenneth G. MacDonald, Charleston, Treasurer. Standing are Drs. Harry S. Weeks, Jr., of Wheeling (left), Alternate Delegate to the American Medical Association, and Richard E. Flood, Weirton, Delegate to the AMA. At the right, Dr. Worthy W. McKinney of Beckley (right) presents the Past President's Plaque to Dr. A. Thomas McCoy, Charleston.

Holdover Councilors whose terms will expire in 1975 are Drs. Robert R. Weiler of Wheeling, Charles E. Andrews of Morgantown, Robert W. Bess, Jr., of Piedmont, Robert D. Hess of Bridgeport, Louis W. Groves, Jr., of Richwood and J. L. Mangus of Charleston.

Dr Frank J. Holroyd of Princeton is a holdover Delegate to the AMA, with Dr. George R. Callender, Jr., of Charleston, as holdover Alternate.

The President

A native of Wheeling, Doctor Gilmore was educated in the public schools of Ohio County and was graduated from West Virginia University in 1939.

He received his M.D. degree in 1943 from the University of Wisconsin Medical School and served an internship at Philadelphia General Hospital. He served as a Lieutenant in the Medical Corps of the U. S. Navy from 1944 to 1946 and was stationed in the Atlantic and Pacific Theaters.

He served a residency in surgery at University Hospitals in Madison, Wisconsin, 1946-50, and then entered the practice of his specialty in Parkersburg following his residency training.

Doctor Gilmore is certified by the American Board of Surgery and is currently serving as Governor of the West Virginia Chapter of the American College of Surgeons. He is a staff surgeon at St. Joseph's and Camden-Clark Memorial hospitals in Parkersburg, and is a Past President of the medical staffs of both hospitals.

In the State Medical Association, Doctor Gilmore has served as a member of the Council, Vice President and President Elect. He is a Past President of the Parkersburg Academy of Medicine and also is a member of the American Medical Association and Southern Medical Association.

Dr. Philip M. Sprinkle To Head 1975 Program Committee

Dr. Philip M. Sprinkle of Morgantown has been named by the President, Dr. William E. Gilmore, to serve as Chairman of the Program Committee for the West Virginia State Medical Association's 108th Annual Meeting at The Greenbrier, August 20-23, 1975.

Other Committee members are Drs. R. J. Bailey of Parkersburg, Fernando G. Giustini of Wheeling, Robert D. Hess of Bridgeport, Jack Leckie of Huntington and Joseph T. Skaggs of Charleston.

The Committee held its initial meeting at The Greenbrier on August 23, and another session is scheduled to be held during the month of October.

Jack Leckie, M. D.
President Elect

He has been active in civic and community affairs in Parkersburg and served for 12 years as team surgeon for the Parkersburg High School athletic teams. He also served as President of the Wood County Heart Association and the Parkersburg Community Concert Association. He is a Trustee of St. Paul's United Methodist Church and is a former Charge Lay Leader.

Doctor Gilmore and his wife, the former Maxine Merrill of Peoria, Illinois, are the parents of two daughters and three sons. Susan and Betsy Gilmore reside in Charlotte, North Carolina; William Gilmore is employed at the Fairmont Hotel in New Orleans; Dr. John Gilmore is taking residency training in Denver; and Scott Gilmore is a junior at Parkersburg High School.

The President Elect

Born in Toler, Kentucky, Doctor Leckie received his undergraduate degree from Marshall University and his M. D. degree in 1950 from the George Washington University School of Medicine. He served his internship at the United States Marine Hospital in New Orleans.

He is a Past President of the Cabell County Medical Society, the West Virginia Chapter of the American Academy of Family Physicians and St. Mary's Hospital. He also has served as a member of the Board of Trustees of Cabell-Huntington Hospital.

Doctor Leckie, who served three years on the State Medical Association's Council, also is a member of the Medical Education and Hospitals Committee and the Legislative Committee.

The Vice President

Doctor Mahood, a native of Bluefield, is a graduate of the University of Virginia and received his M. D. degree in 1947 from that institution's Medical School. He served his internship and residency at Detroit Receiving Hospital and did postgraduate work in dermatology at Wayne State University School of Medicine, 1948-52.

Doctor Mahood served as President of the Mercer County Medical Society in 1963-64 and has been Secretary of the Society since 1965. He was named to fill an unexpired term on the Council in 1969 and later was elected to two terms on the Council beginning in 1971.

He is a past Chairman of the Association's Medical Emergencies and Civil Defense Committee, of which he has been a member since 1965, and also is a member of the Nurses Liaison Committee.

First House Session

Dr. Malcolm C. Todd, President of the American Medical Association, was speaker for the first session of the House of Delegates on Wednesday afternoon. Doctor Todd told physicians it was his belief that there would be no national health insurance legislation in Congress this year.

Doctor McCoy presented Dr. David Z. Morgan, Associate Dean of the West Virginia University School of Medicine, with a check for $13,962 during the initial House session.

This represented an annual contribution by West Virginia physicians and Woman's Auxiliary members to the School of Medicine through the Education and Research Foundation of the AMA.

Senator Byrd Addresses Opening Session

Sen. Robert C. Byrd of West Virginia, Majority Whip of the United States Senate, addressed the physicians during opening exercises preceding the first general scientific session.

Senator Byrd reviewed the Watergate case and former President Nixon's resignation, then proposing that the impeachment process in the United States should be made "less ponderous." He suggested the possibilities of a referendum or recall elections for removal of a President from office, adding "I don't say we should adopt such proposals, but they are worth study."

Resolutions

Delegates grappled with a record number of 12 resolutions during the final House session on Saturday, August 24. The resolutions were addressed to a variety of subjects, including a new policy statement on PSRO, problems with third-party agencies, an endorsement of Dr. Carl B. Hall of Charleston for the office of President Elect of the American Academy of Family Physicians, and the endorsement of the State Judicial Reorganization Amendment.

The delegates defeated a resolution seeking income tax credit for physicians in West Virginia who have not received the usual and customary fee in rendering services to Welfare recipients, children enrolled in the Crippled Children's services, Division of Vocational Rehabilitation patients and those whose injuries are incurred under Workmen's Compensation law. In defeating the resolution, the delegates were accepting the recommen-

Dr. Malcolm C. Todd (right), President of the American Medical Association, talks with Dr. Frank J. Holroyd of Princeton in the left photo. Doctor Holroyd is a State Medical Association Delegate to the AMA. Doctor Todd was speaker for the first session of the House of Delegates on Wednesday at the State Medical Association's Annual Meeting. Dr. A. Thomas McCoy of Charleston, second from left in the right photo, greets Sen. Robert C. Byrd of West Virginia who spoke during opening ceremonies Thursday morning. Also shown are Dr. Hawey A. Wells, Jr. of Princeton (left) and Dr. J. Hugh Wiley of Morgantown, Program Chairman for the Annual Meeting.

Shown during a lighter moment at the State Medical Association's Annual Meeting are, in the left photo, from left, Drs. William E. Gilmore of Parkersburg, President; Barbara Jones of Morgantown and John A. Martin of Virginia, President of the Medical Society of Virginia. In the right photo, Dr. Isaiah A. Wiles of Morgantown (left) and Dr. Del Roy R. Davis of Kingwood (center), talk with Guy Beaumont of Columbus, Ohio, the American Medical Association Field Service Representative to West Virginia.

dation of the Resolutions Committee, which noted that it "agreed in principle" with the resolution.

Following is a summary of the resolution adopted by the delegates which, in each case:

- Referred to the Executive Committee for study and report back to the House of Delegates at the 1975 Annual Meeting a resolution pertaining to Statewide Unified Membership in the American Medical Association.
- Directed the State Medical Association to take whatever action is necessary to make it compulsory that insurance carriers doing business in West Virginia use and accept the standard AMA Claim Form for physician and patient claims and reports in the State.
- Directed the State Medical Association to encourage its component medical societies to develop a satisfactory referral system to assist persons desiring medical care.
- Directed the State Medical Association to notify the Secretary of Health, Education and Welfare of its intentions to press for corrective amendments to PL 92-603 to insure that the quality aspects assuring adequate high level care are enhanced; advises the members of the State Medical Association who are also members of the West Virginia Medical Institute, Inc., to proceed carefully and cautiously in implementation of the present PSRO statute, and calls on the Institute to proceed to develop and adopt a uniform, all-patient peer review system; and urges that the Institute pursue all avenues of financial support, not Federal alone, to create an effective and unassailable peer review system (The resolution was amended to honor the right of any member of the State Medical Association to elect nonparticipation in the current West Virginia PSRO plan).
- In view of the policy of the United Mine Workers Welfare and Retirement Fund to remove the names of participating physicians when there is a disagreement or conflict in medical or fiscal matters without the utilization of the grievance mechanisms established by the medical profession or the benefit of peer review; and whereas the removal of participating physicians by the Area Administrator for UMW District 17 has interfered in the free choice of physicians and hospital facilities, as well as the normal doctor-patient relationship; and whereas such action has interfered with the availability of quality medical care within a reasonable distance of many beneficiaries; therefore directs the State Medical Association:

To enter into negotiations with the United Mine Workers Welfare and Retirement Fund in an attempt to terminate these activities and, if these negotiations fail, to condemn the UMW Welfare and Retirement Fund for the activities they are participating in which interfere in the private practice of medicine in the provision of continued quality medical care for their beneficiaries and totally disregard the established mechanisms for quality control in the name of economic responsibility; and that the State Medical Association make this censorship public and cite such activities as an example of what a third party which provides financial reimbursement for medical services can

Dues Increase Approved

The House of Delegates of the West Virginia State Medical Association adopted the following amendment to the By-Laws during the 1974 Annual Meeting at The Greenbrier, which will be effective January 1, 1975:

Amend Chapter 1, Section 7, by deleting the figure, "$100," and substituting therefore the figure, "$150."

do by interfering in the provision of medical care to the jeopardy of the health of its beneficiaries.

• Directed the State Medical Association to request the Commissioner of the West Virginia Department of Welfare to meet with the Medical Economics Committee of the Association to consider the freedom of choice of physicians and, in some instances, choice of hospitals, which for years has been denied to the recipients of Crippled Children's services of the West Virginia Department of Welfare; that this lack of freedom of choice produces an undue hardship for some of these patients, and that the money used on transportation of these patients to distant hospitals and physicians could better be used for the actual care of the patients.

• Directed the House of Delegates and the State Medical Association to recommend to the West Virginia Medical Institute, Inc. that it continue to develop the Voluntary Office Self-Audit Service program, believing that this program can be a valuable tool to physicians desiring alternate means of continuing medical education, that it can play an important role in determining the State's continuing medical education needs; and in view of the fact the State Medical Association's Committee on Medical Education and Hospitals unanimously voted to request this action.

• Endorsed by acclamation the candidacy of Dr. Carl B. Hall of Charleston for the office of President Elect of the American Academy of Family Physicians and stressed the importance that friends of Doctor Hall contact colleagues in other states to enlist support for Doctor Hall's candidacy.

• Approved the policy on abortion as adopted by the American Medical Association in 1970, approved by the Council in 1971 and reaffirmed by the House of Delegates in 1972.

• Endorsed the Judicial Reorganization Amendment and encouraged members of the State Medical Association to familiarize themselves with the Amendment and urge its study and adoption by the voters of the State of West Virginia at the November 5, 1974 general election.

• When a third-party agency notifies a patient that charges are excessive when they exceed the agency's schedule of maximum allowance and further offers financial assistance to legally combat recovery suits, directs the State Medical Association to request that such activities cease and direct to the third-party agency the following statement: "The West Virginia State Medical Association reminds you that your agreement is with your client and not with the client's attending physician and that you should advise such clients that their insurance benefits may not completely cover all medical services rendered; in fact, in such instances they of course would be responsible for the difference, if any, to the physician engaged by themselves to provide such services."

Reception For Honor Guests

A reception was held on Wednesday evening, August 21, for honor guests. In addition to scheduled speakers, other out-of-state guests included the following presidents of neighboring state medical associations and their wives:

Dr. and Mrs. James L. Henry of Ohio, Dr. and Mrs. John A. Martin of Virginia, Dr. and Mrs. A. Reynolds Crane, President Elect of the Pennsylvania Medical Society, and Dr. Joseph E. Dukes of Indiana.

Other guests were Mrs. Howard Liljestrand of Honolulu, Hawaii, President of the Woman's Auxiliary to the American Medical Association, and Doctor Liljestrand; and Mrs. W. Nash Thompson of Stuart, Virginia, President of the Woman's Auxiliary to the Southern Medical Association, and Doctor Thompson.

Shown on the left during the President's Reception for Honor Guests at the State Medical Association's Annual Meeting are, from left, Dr. Joseph E. Dukes, President of the Indiana State Medical Association, and Dr. and Mrs. James L. Henry of Ohio. Doctor Henry is President of the Ohio State Medical Association. In the center photo, Dr. Eldon B. Tucker of Morgantown, Chairman of the State Medical Association's Committee on Aging, shows his exhibit on the Transportation Remuneration Incentive Program (TRIP). In the right photo are Mrs. John N. Robinson, President of Maryland's woman's auxiliary, and her son, Richard.

Pre-Convention Council Meeting At The Greenbrier

The Pre-Convention Meeting of the Council was held at The Greenbrier in White Sulphur Springs on Wednesday, August 21, with the Chairman, Dr. Worthy W. McKinney of Beckley, presiding.

At the outset, Doctor McKinney requested that he be officially recorded as thanking all officers and members of the Council for their splendid cooperation in helping him to carry out his duties as Chairman during a year which proved to be difficult for the profession — both within the State and nationally.

He also introduced Mr. Guy D. Beaumont of Columbus, Ohio, Field Representative for the American Medical Association.

Resolutions

Doctor McKinney announced that a large number of resolutions would be offered at the first session of the House of Delegates that afternoon and urged all members of the Council and other interested physicians to attend a meeting of the Resolutions Committee on Thursday afternoon.

On motion of Doctor Callender, seconded by Doctor Andrews, the Council voted unanimously to recommend to the Resolutions Committee and House of Delegates that the resolution pertaining to passage of the Judicial Reorganization Amendment in the 1974 general election be endorsed.

(Subsequent action taken by the House of Delegates on this and other resolutions may be found elsewhere in this issue of *The Journal*).

Report of Medical Economics Committee

Dr. Carl J. Roncaglione of Charleston, Chairman of the Medical Economics Committee, presented a detailed report concerning activities of the members and committees of the State Medical Association in the field of medical economics during the past year.

Doctor Roncaglione discussed in depth many of the Association's problems with third-party agencies and suggested remedies for same.

He specifically urged those present to read the resolutions to be introduced that afternoon since many would pertain to the subject matter he presented before the Council.

Doctor Roncaglione also urged that all Chairmen of sub-committees of the parent Medical Economics Committee keep him informed of activities on a current basis rather than submitting reports on a periodic or end-of-the year basis.

Dr. A. Thomas McCoy, the President, complimented Doctor Roncaglione on his presentation and the Council voted unanimously to approve the report.

1975 Meeting at The Greenbrier

It was reported that the management at The Greenbrier was holding the dates August 20-23, 1975, for the 108th Annual Meeting of the West Virginia State Medical Association.

The Council voted unanimously to approve The Greenbrier as the place for the 1975 meeting during the above mentioned dates.

Proposed Dues Increase

Members of the Council discussed the need for an increase in State dues for members of the Association due to many factors — primarily the general inflation affecting the country, increase in postal rates, office supplies, increase in the number of medical scholarships from two to four, salary increases, cost of printing *The Journal*, travel expenses, etc.

The Council unanimously approved a recommendation that the dues for members of the State Medical Association be increased from $100 to $150, effective January 1, 1975, and that an amendment to the By-Laws be prepared and introduced at the first session of the House of Delegates that afternoon.

Guests at Meeting

Doctor McKinney introduced the following guests at the meeting: The Hon. Samuel H. Weese, State Insurance Commissioner; the Hon. B. Frederick Becker, Workmen's Compensation Commissioner; Dr. Paul S. Metzger and Mr. Richard E. Lenhart, representing Nationwide Mutual Insurance Company.

The guests expressed appreciation for being invited to attend the meeting and gave brief reports concerning their agencies' roles in helping to work with physicians in bringing about a good working relationship with the profession.

Doctor McKinney reported he had received a letter of regret from the Hon. Edwin F. Flowers, Commissioner of the Department of Welfare. He said Mr. Flowers was unable to attend due to another conflicting meeting.

Retiring Councilors

Doctor McKinney took time during the meeting to commend the following four physicians for their four consecutive years of dedicated service as members of the Council: Drs. Robert R. Pittman of Martinsburg; F. Lloyd Blair of Parkersburg; Richard G. Starr of Beckley; and Thomas P. Long of Man.

On motion by Doctor McCoy, and unanimously approved by the Council, Doctor McKinney was praised and given an ovation for his capable service as Chairman of the Council during the past year.

The meeting was attended by Dr. Worthy W. McKinney of Beckley, Chairman; Dr. A. Thomas McCoy of Charleston, President; Dr. William E. Gilmore of Parkersburg, President Elect; Dr. Jack Leckie of Huntington, Vice President; Dr. Harry S. Weeks, Jr., of Wheeling, Councilor at Large; Dr. George R. Callender, Jr., of Charleston, Junior

Councilor; Drs. Robert R. Weiler of Wheeling; Charles E. Andrews of Morgantown; Robert R. Pittman of Martinsburg; Robert D. Hess of Bridgeport; Louis W. Groves, Jr., of Richwood; Harold N. Kagan of Huntington; J. L. Mangus and W. Alva Deardorff of Charleston; Richard G. Starr of Beckley; John J. Mahood of Bluefield; and Thomas P. Long of Man; Mr. William H. Lively of Charleston, Executive Secretary; and Mr. Charles R. Lewis of Charleston, Special Projects Director.

Also attending the meeting were Drs. Frank J. Holroyd of Princeton and Richard E. Flood of Weirton, AMA Delegates; Dr. N. H. Dyer, Director of the State Health Department; Dr. Mildred Mitchell-Bateman, Director of the State Mental Health Department; Mr. Guy D. Beaumont, Jr., of Columbus, Ohio, AMA Field Representative; Dr. Carl J. Roncaglione of Charleston, Chairman of the Association's Medical Economics Committee; L. J. Pace of Princeton, a Past President of the Association; Hon. B. Frederick Becker, Workmen's Compensation Commissioner; Hon. Samuel H. Weese, State Insurance Commissioner; and Dr. Paul S. Metzger and Richard E. Lenhart, representing Nationwide Mutual Insurance Company.

Affiliated Societies, Sections Elect New Officers

Some of the scientific sections, associations and societies affiliated with the West Virginia State Medical Association elected new officers at sessions during the Association's Annual Meeting at The Greenbrier. The groups and new officers reported included:

Section on Surgery — Dr. S. William Goff, Parkersburg, Chairman.

Section on Orthopedic Surgery — Drs. Robert L. Ghiz, Charleston, President; Tony C. Majestro, Charleston, Vice President; and Arthur A. Abplanalp, Charleston, reelected Secretary-Treasurer.

West Virginia Radiological Society — Drs. James T. Smith, Charleston, President; Orlando F. Gabriele, Morgantown, Vice President; and Andrew W. Goodwin, II, Charleston, reelected Secretary-Treasurer.

Section on Neurology, Neurosurgery and Psychiatry — Drs. Arthur L. Poffenbarger, Charleston, President, and Hartwell G. Thompson, Charleston, Secretary.

Section on Internal Medicine — Dr. Harold Selinger, Charleston, Chairman.

Section on Urology — Drs. A. Thomas McCoy and James W. Lane, both of Charleston, President and Vice President, respectively.

West Virginia Chapter, American Society of Internal Medicine — Drs. John F. Otto, Jr. and William J. Echols, both of Huntington, President and Secretary, respectively.

Dr. Carl B. Hall's Candidacy Endorsed By Association

Dr. Carl B. Hall's candidacy for President Elect of the American Academy of Family Physicians was unanimously endorsed by the State Medical Association during its Annual Meeting at The Greenbrier in White Sulphur Springs, August 21-24. A resolution endorsing Doctor Hall's candidacy was adopted unanimously and by acclamation at the final session of the House of Delegates on Saturday, August 24.

Carl B. Hall, M. D.

Doctor Hall, who has practiced medicine in Charleston since 1946, currently is serving as Chairman of the Board of Directors of the AAFP. The election will be held during the Annual Meeting of the Academy in Los Angeles, October 14-17. The text of the resolution follows:

WHEREAS, Carl B. Hall, M.D., has allowed his name to be placed in nomination for the office of President Elect of the American Academy of Family Physicians; and

WHEREAS, He has been fully trained by many years of experience and loyal service to his county, state and national medical organizations;

THEREFORE, BE IT RESOLVED, That the West Virginia State Medical Association go on record as fully endorsing his candidacy for this high office, and pledging our full support wherever appropriate and proper; and

BE IT FURTHER RESOLVED, That copies of this Resolution be signed by the President and sent forthwith to all the officers and delegates of the Congress of Delegates of the American Academy of Family Physicians.

(The latter directive subsequently was carried out by the President of the State Medical Association).

1975 Meeting at The Greenbrier

The Council decided, at its pre-convention session, to hold the West Virginia State Medical Association's 1975 Annual Meeting at The Greenbrier in White Sulphur Springs. The meeting, the Association's 108th, will be held August 20-23.

Dr. Robert C. Parlett Named Dean Of Marshall Medical School

Dr. Robert C. Parlett of Springfield, Illinois, was appointed Vice President of Health Sciences and Dean of the medical school at Marshall University, effective September 1.

Robert C. Parlett, M.D.

The announcement was made on August 29 in Charleston by Governor Arch A. Moore, Jr. Doctor Parlett was present for the governor's press conference along with Dr. Ben L. Morton, Chancellor of the West Virginia Board of Regents. Dr. Robert B. Hayes, interim President of Marshall, and Dr. Albert C. Esposito, one of the leaders in the effort to establish a medical school at Marshall.

The new Marshall Vice President-Dean currently is Associate Dean of the Southern Illinois University School of Medicine, Medical Sciences, a position he has held since 1972.

From 1962 to 1972 he was Professor and Chairman of the George Washington University Medical School Department of Microbiology. He also has served on the faculty of Northwestern University Medical School.

President Hayes noted that Doctor Parlett has had a distinguished research career in the field of microbiology and has a long record of involvement with the Veterans Administration.

Marshall has received preliminary approval of its application for Veterans Administration funding assistance in the establishment of a medical school in cooperation with the Huntington VA Hospital.

Doctor Parlett, 49, was born at the Albuquerque Indian School in New Mexico where his father was an Indian Service physician and his mother was a registered nurse. He graduated from high school in Tucson, Arizona, and received his A.B. and M.A. degrees from the University of Arizona. He earned his Ph.D. degree in immunology-microbiology and his M. D. degree from Northwestern University.

A veteran of World War II, Doctor Parlett graduated from the U. S. Navy V-12 Officers Training Program at Southern Methodist University. He served as executive officer of a patrol vessel in the Philippine Islands.

Active in a number of professional societies, Doctor Parlett has served as a consultant to the World Health Organization, the Veterans Administration Center at Martinsburg, and the Public Health Service. Between 1960 and 1972, he was awarded five major research grants. He is the author of many articles published in professional journals.

At Southern Illinois, he has been involved in the operation of a medical school which utilizes community hospitals for its clinical training, including a Veterans Administration hospital. A similar program is envisioned for the Marshall Medical School.

"I am very happy that Doctor Parlett has accepted the exciting challenge of leading the development of the Marshall Medical School," Doctor Hayes said. "Not only does he have excellent background and training for this position, but he has a breadth of interests which is most suitable to a university setting. He also brings to Marshall a remarkable enthusiasm which bodes well for the future of this program."

Dr. John W. Traubert (seated, center), Chairman of the new Department of Family Practice at West Virginia University School of Medicine, discusses schedules with the program's first four residents at the University, Dr. Michael J. Lewis of Charleston (seated, left), Dr. Patrick Kelleher of Sarasota Springs, New York and Dr. Dale J. Luketich of Weirton (standing, from left), and Dr. David W. Nesselroade of Williamstown (right). Doctor Kelleher, a 1974 graduate of Dartmouth Medical School, and the three 1974 graduates of WVU School of Medicine began their residencies in July. WVU also has five Family Practice residents in the Kanawha Valley program located at Herbert J. Thomas Memorial Hospital at South Charleston.

Dr. Philip M. Sprinkle of Morgantown (left), Moderator for the First General Session of the State Medical Association's Annual Meeting, poses with the guest speakers at this session. They are, from left, Drs. Charles H. Kirkpatrick of Bethesda, Maryland; Jack M. Gwaltney, Charlottesville, Virginia; Virgil M. Howie, Huntsville, Alabama, and Robert W. Veltri, Ph. D., Morgantown.

Participating in the Second General Scientific Session were, from left, Drs. James F. Glenn of Durham, North Carolina, Allen H. Mackenzie, Cleveland, both guest speakers, and Winfield C. John, Huntington, Moderator. Not shown is Dr. Robert F. Schilling of Madison, Wisconsin, another guest speaker.

The entire family was present during the Annual Meeting for the installation of Dr. William E. Gilmore of Parkersburg as President of the State Medical Association. Seated with Doctor and Mrs. Gilmore (Maxine) are their daughters, Miss Susan Merrill Gilmore (left) and Miss Betsy Shaffer Gilmore (right), both of Charlotte, North Carolina; standing, from left, sons Scott M. Gilmore, a junior at Parkersburg High School; William E. Gilmore, Jr. and his wife, Bonnie, of New Orleans, and John W. Gilmore, M. D., Denver.

A reception honoring officers of the State Medical Association was held during the final evening of the Annual Meeting. Shown in the receiving line are, from left, Dr. and Mrs. J. Dennis Kugel of Charleston, Dr. and Mrs. Malcolm C. Todd of Long Beach, California and Dr. and Mrs. A. Thomas McCoy of Charleston. Mrs. Kugel is the immediate Past President of the Woman's Auxiliary to the State Medical Association. Doctor Todd is President of the American Medical Association and Doctor McCoy, immediate Past President of the State Medical Association, also is Chairman of the Association's Council.

Doctor Ray M. Kessel of Logan (left) was Moderator for the Third General Session of the Annual Meeting. The speaker was Dr. John W. Traubert of Morgantown (center). Dr. J. Hugh Wiley of Morgantown (right) served as Moderator for an open-floor discussion which followed Doctor Traubert's address.

Members of the State Medical Association's Publication Committee are shown after a luncheon during the Annual Meeting. From left, are Drs. Vernon E. Duckwall of Elkins, Thomas J. Holbrook, Huntington, John M. Hartman, Charleston, and Joe N. Jarrett, Oak Hill, all Associate Editors of The Journal, and George F. Evans, Clarksburg, Editor of The Journal. Not shown are Drs. E. J. Van Liere of Morgantown and Stephen D. Ward, Wheeling, The Journal's other Associate Editors.

Mrs. William T. Lawson Installed As Auxiliary President

Mrs. William T. Lawson of Fairmont assumed the Presidency of the Woman's Auxiliary to the West Virginia State Medical Association at the group's 50th Annual Meeting at The Greenbrier in White Sulphur Springs August 21-24.

Mrs. William T. Lawson

Mrs. Lawson, who was installed by Mrs. Howard J. Liljestrand, President of the Woman's Auxiliary to the American Medical Association, announced that the 1974-75 Auxiliary theme will be "To Care Is To Share."

The wife of a family physician and mother of two children, Mrs. Lawson succeeded Mrs. J. Dennis Kugel of Charleston. The Auxiliary elected Mrs. Robert R. Weiler of Wheeling as President Elect, and the following additional officers:

Mrs. James H. Walker of Charleston, Vice President; Mrs. Claude S. Lawson, Jr., Fairmont, Recording Secretary; Mrs. Kenneth D. Bailey, Fairmont, Corresponding Secretary; Mrs. Louis W. Groves, Richwood, Treasurer, and Mrs. Rupert W. Powell, Fairmont, Parliamentarian.

Mrs. Robert J. Reed, III, Wheeling, Northern Regional Director; Mrs. D. Sheffer Clark, Huntington, Western Regional Director; Mrs. E. G. Friera, Romney, Eastern Regional Director, and Mrs. R. James Yates, Beckley, Southern Regional Director.

Committee Appointments

Mrs. Lawson also announced these appointments of Committee Chairmen:

Mrs. Paul Francke, Jr., Charleston, AMA Education and Research Foundation; Mrs. Pat A. Tuckwiller, Charleston, Archives and History, and WESPAC; Mrs. M. Bruce Martin, Huntington, By-laws and Handbook; Mrs. T. Keith Edwards, Bluefield, Editor, State News Bulletin; Mrs. P. P. Ferraraccio, Bluefield, Circulation Manager; Mrs. George Thomas Evans and Mrs. Harry C. Fleming, both of Fairmont, Convention Chairman and Co-Chairman, respectively; Mrs. E. G. Cadogan, Fairmont, Health Education; Mrs. Joseph T. Mallamo, Fairmont, Health Careers; Mrs. Robert G. Janes, Fairmont, Cook Book;

Mrs. Charles E. Andrews, Morgantown, Finance; Mrs. J. N. Jarrett, Oak Hill, Communications and *md's wife;* Mrs. William N. Walker, Jr., Bridgeport, Family Health; Mrs. E. M. Spencer, Bluefield, Community Health; Mrs. Hu C. Myers, Philippi, International Health; Mrs. J. E. Blaydes, Jr., Bluefield, Legislative;

Mrs. John D. H. Wilson, Clarksburg, Necrology; Mrs. John E. McKenzie, Beckley, Press and Publicity; Mrs. Joseph E. Ricketts, Huntington, Southern Medical Councilor, and Mrs. George A. Curry, Morgantown, Woman's Auxiliary to the Student American Medical Association.

Mrs. Lawson, a native of West Virginia, attended Fairmont State College, majoring in Elementary Education. She taught school for three years prior to her marriage. She and Doctor Lawson are the parents of Mrs. C. R. (Barbara) Kinder, whose husband, Doctor Kinder, is a professor at Miami University at Oxford, Ohio; and William T. (Bill) Lawson, Jr., a graduate of North Carolina State University and now a science teacher and coach at Fairmont Senior High School. Dr. and Mrs. Lawson have four grandchildren.

Active in community life, Mrs. Lawson currently is serving as Chairman of the Executive Committee of the First Baptist Church. She is the immediate Past State President of the P.E.O., and is a member of the Fairmont General Hospital Volunteer Association, Morning Gardeners, D.A.R., Eastern Star, White Shrine and Fairmont Woman's Club.

The new President has been active in the county auxiliary since 1946, holding various chairmanships and offices, including President. In the State auxiliary, she has served as By-Laws Chairman, Parliamentarian on two occasions, Convention Chairman on two occasions, Corresponding Secretary, Treasurer and President-Elect.

Clinical Chemistry, Pathology Seminar Scheduled At WVU

A Seminar in Clinical Chemistry and a Continuing Education Program in Clinical Pathology will be held on Friday and Saturday, November 1-2, at the West Virginia University School of Medicine in Morgantown.

The program is scheduled for the entire day on Friday, November 1, and will conclude at noon on Saturday. Dr. Vicente Anido, Professor and Chairman of the Division of Clinical Laboratories, said the Continuing Education Program in Clinical Pathology has been approved by the American Society of Clinical Pathologists and provides credit hours.

The faculty will include Drs. Nathaniel Rodman, Chairman, Department of Pathology, WVU; John E. Jones, Dean, WVU School of Medicine; E. Shrae LaPlante, Assistant Professor, Department of Surgery, WVU; Jeffrey Shultz, Assistant Professor, Department of Medicine and Clinical Pathology, WVU;

Paul E. Strandjord, Professor and Chairman, Department of Laboratory Medicine, University of Washington School of Medicine, Seattle; Richard Iammarino, Associate Professor, Clinical Pathology, Presbyterian Hospital, Pittsburgh; Sylvan M. Sax (Ph. D.), Chief, Clinical Chemistry, Western Pennsylvania Hospital, Pittsburgh; Paul E. Steffes, Assistant Professor of Medicine, WVU;

Robert W. Veltri (Ph. D.), Associate Professor, Microbiology and Otolaryngology, WVU; W. Keith C. Morgan, Professor, Department of Medicine, WVU; Mrs. Marcia Sell, MT (ASCP), Computer Manager, WVU Hospital Clinical Laboratories; Miss Ida Yoder, MT (ASCP) MS, Chief, Chemistry Laboratory, WVU Hospital Clinical Laboratories; Robert S. Salisbury, Assistant Professor, Clinical Pathology, WVU; and Doctor Anido.

The registration fee is $25. Checks may be made payable to the West Virginia University Foundation and mailed to: Mr. W. A. Pearse, WVU Conference Office, 389 Birch Street, Morgantown, W. Va. 26506.

Family Practice Residency Approved in Clarksburg

Word was received August 26, 1974, that the United Hospital Center, with the support of the Clarksburg Veterans Administration Hospital, has been approved for a residency program in Family Practice.

Approval was granted to accept a maximum of four residents each year for a three-year program — a total of 12 residents beginning July 1, 1975.

It is anticipated that this program will provide a source of new physicians in this specialty for Central West Virginia.

Mrs. Howard J. Liljestrand of Hawaii, President of the Woman's Auxiliary to the American Medical Association, was a guest of the Woman's Auxiliary to the West Virginia State Medical Association during its 50th Annual Meeting at The Greenbrier in White Sulphur Springs August 21-24. Mrs. Liljestrand, standing (left), is shown here with the 1974-75 State Auxiliary officers at the conclusion of the Annual Meeting. The officers are, standing, from left, Mrs. William T. Lawson of Fairmont, President; Mrs. J. Dennis Kugel, Charleston, immediate Past President; Mrs. James H. Walker, Charleston, Vice President; Mrs. Claude S. Lawson, Jr., Fairmont, Corresponding Secretary; Mrs. Louis W. Groves, Richwood, Treasurer; Mrs. Robert J. Reed, III, Wheeling, Northern Regional Director, and Mrs. Kenneth D. Bailey, Fairmont, Corresponding Secretary; seated from left, Mrs. Robert R. Weiler, Wheeling, President Elect; Mrs. D. Sheffer Clark, Huntington, Western Regional Director, and Mrs. E. G. Friera, Romney, Eastern Regional Director. Not shown are Mrs. R. James Yates, Beckley, Southern Regional Director, and Mrs. Rupert W. Powell, Fairmont, Parliamentarian.

108th ANNUAL MEETING

of the

West Virginia State Medical Association

The Greenbrier

AUGUST 20-23, 1975

PLAN NOW TO ATTEND

Two Additional Speakers Named For Mid-Winter Conference

A psychiatrist and a pediatrician, both of Charleston, have accepted invitations to speak at the Eighth Mid-Winter Clinical Conference next January 24-26 in Charleston at the Daniel Boone Hotel. Dr. Ralph S. Smith, Jr. will discuss teenage suicides under the general topic of "Problems of Adolescents," which also will include speakers who will explore teenage pregnancies, drugs and alcoholism. There will be a public session on Friday evening, January 24, and a medically - oriented session featuring the same speakers Saturday morning, January 25.

William C. Felch, M. D.

Dr. Nancy Wanderman, Assistant Professor of Pediatrics, Pediatric Cardiology, in the Charleston Division of the West Virginia University Medical Center, will speak during the opening session Friday afternoon on "Cardiac Emergencies in Children."

The Conference will conclude at noon on Sunday, with scientific sessions scheduled for Friday afternoon, Friday evening, Saturday morning and afternoon, and Sunday morning.

Concurrent with the public program Friday evening will be a session for physicians on PSRO entitled "PSRO Revisited One Year Later."

Speakers and their topics previously announced include:

"Mobile Coronary Care Unit" — Richard S. Crampton, M. D., Department of Internal Medicine, University of Virginia Medical Center (Friday Afternoon); "Human Sexuality and Youth, A Timely Challenge" — U. G. Turner, III, M. D., Assistant Professor, Department of Obstetrics and Gynecology, University of Virginia School of Medicine, and Gynecology Consultant to the Department of Student Health (Friday Evening and Saturday Morning); "PSRO Revisited One Year Later" — Dr. James C. Respess, Department of Internal Medicine, University of Virginia School of Medicine, and Dr. William C. Felch of Rye, New York, the 1973-74 President of the American Society of Internal Medicine (Friday evening physician's session);

"The Diagnosis and Medical Management of Cerebral Vascular Disease" — Arthur L. Poffenbarger, M. D., Charleston (Saturday Afternoon); "Pulmonary Disease in Adolescents" — C. E. Buckley, III, M. D., Department of Medicine, Duke University Medical Center (Sunday Morning), and "How to Avoid Malpractice" — Stanley E. Preiser, Charleston attorney (Sunday Morning).

To be announced are additional speakers for vascular diseases and cancer.

The West Virginia University School of Medicine Alumni Association will meet Friday afternoon preceding the evening session.

Physicians, wives and guests will be invited to attend the annual dinner dance of the Kanawha Medical Society Saturday evening at the Daniel Boone.

Attendance at the Conference will be acceptable for Category 1 credit toward the Physician's Recognition Award of the American Medical Association; the Conference also is expected to carry prescribed credit by the American Academy of Family Physicians. A registration fee of $15 for the entire conference will be charged all registrants except nurses, medical students, interns and residents.

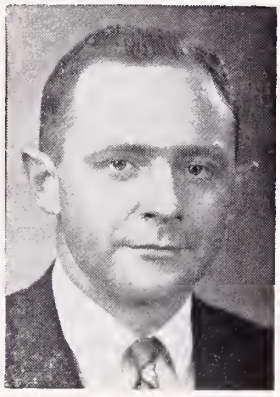
The program Co-Chairmen again are Drs. Ralph H. Nestmann and Joseph T. Skaggs, both of Charleston. Also on the Program Committee are Drs. William O. McMillan, Jr. of Charleston and C. Carl Tully of South Charleston.

The annual Mid-Winter Conference is sponsored by the State Medical Association in conjunction with some of its component medical groups and volunteer health agencies.

Additional details will be provided in later issues of *The Journal* as the program takes final shape.

Drs. Blaydes, Esposito To Speak At Ophthalmology Meeting

The American Academy of Ophthalmology and Otolaryngology has announced that two West Virginia physicians will conduct postgraduate lecture courses at its annual convention in Dallas, Texas, October 6-10.



J. E. Blaydes, Jr. M.D.

Albert C. Esposito, M.D.

Dr. J. Elliott Blaydes, Jr., of Bluefield, and Dr. Albert C. Esposito of Huntington, will each conduct separate seminars. Doctor Blaydes will cover

"Techniques of Handling Fine Absorbable Sutures in Cataract Surgery" while Doctor Esposito will repeat his course on "General Anesthesia, Local and Neuroleptic Analgesia in Ocular Surgery."

The meeting's keynote address is to be given by Dr. Charles C. Edwards, Assistant Secretary of Health, Education, and Welfare. Dr. Frank W. Newell of Chicago, a classmate of Doctor Esposito's, will be installed as President of the Academy at the conclusion of this meeting.

The attendance is scheduled to break previous attendance records for the meeting in Dallas and will bring the various latest medical and surgical techniques and therapy in ophthalmology to the members and guests present. Physicians throughout the world are scheduled to be in attendance.

David Brinkley To Be Guest Speaker At Wheeling Clinic Seminar

Special guest speaker David Brinkley will highlight the Wheeling Clinic's Saturday banquet which will cap its Golden Jubilee Scientific Seminar in Medicine and Surgery October 18-19. The Seminar will be held at Wheeling's Oglebay Park.

The program will offer a wide-ranging clinical and educational experience for the attending physicians. Registration has been limited to 100 physicians who will receive 12 hours of credit approved by the American Academy of Family Physicians.

David Brinkley

The seminar is part of Wheeling Clinic's 50-year Golden Jubilee observance. The clinic, located at 58 Sixteenth Street, is staffed by 25 physicians, including specialists in many fields.

Mr. Brinkley will speak following the concluding dinner to be held at the Ramada Inn at Dallas Pike. Brinkley, who recently completed his 30th year with NBC News, has spent most of his career covering the day's news from the nation's capital. He currently anchors a series of personal reports of and about the news under the title of "David Brinkley's Journal," a colorcast on "NBC Nightly News" five times a week.

Mr. Brinkley has received every major broadcasting award, and his writing has been described as "the best ever done in television journalism." The quality most often identified with Brinkley is his sharp wit. During his years as co-anchorman of "The Huntley-Brinkley Report," that program won many major television news awards.

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled in the coming months.

1974

Oct. 5-8—Am. Assn. of Ophthalmology, Dallas.
Oct. 6-10—Am. Acad. Oph. & Otol., Dallas.
Oct. 14-17—AAFP, L. A.
Oct. 16-18—Am. Cancer Society, New York.
Oct. 17-19—Am. Assn. for Surgery of Trauma, Hot Springs, Va.
Oct. 18-19—Golden Jubilee Sem. In Med. and Surgery (Wheeling Clinic), Wheeling.
Oct. 19-24—Am. Acad. Pediatrics, San Fran.
Oct. 20-22—Am. Coll. Preventive Med., N. Orleans.
Oct. 21-25—ACS Clinical, Miami Beach.
Oct. 21-26—Am. Coll. Gastroent., Bal Harbour, Fla.
Oct. 23-26—Pa. Medical Soc. Scientific, Harrisburg.
Oct. 24-26—Pot.-Shen. PG Institute, Martinsburg.
Oct. 24-27—Am. Acad. Child Psychiatry, San Fran.
Oct. 29-30—Am. Assn. Study of Liver Diseases, Chicago.

Nov. 1-2—Clinical Chemistry, Pathology Sem., Morgantown.
Nov. 1-3—Med. Soc. of D. C., White Sul. Springs.
Nov. 3-4—Am. Coll. of Chest Physicians, New Orleans.
Nov. 3-6—Med. Soc. Va., Williamsburg.
Nov. 6-9—Am. Soc. Cytology, N. Y. City.
Nov. 9-14—Am. Soc. Maxillofacial Surgeons, Houston.
Nov. 14-16—W. Va. Chap., ACS, Morgantown.
Nov. 16-20—Amer. Acad. for Cerebral Palsy, Denver.
Nov. 17-20—Southern Med. Assn., Atlanta.
Nov. 18-22—Am. Heart Assn., Dallas.
Nov. 21-24—Clinical Immunology and Allergy, Ft. Lauderdale, Fla.
Nov. 30-Dec. 4—AMA Clinical, Portland.

Dec. 1-6—Radiological Society of N. America, Chicago.
Dec. 7-10—Am. Soc. Hematology, San. Fran.
Dec. 7-12—Am. Acad. Dermatology, Chicago.
Dec. 9-12—Southern Surgical Assn., Boca Raton, Fla.
Dec. 16-17—New Drug Sem. (Natl. Cancer Institute), Washington, D. C.

1975

Jan. 24-26—8th Annual Mid-Winter Clinical Conf., Charleston.
Jan. 31-Feb. 2—Southern Radiological Conf., Point Clear, Ala.
Feb. 10-13—Am. College Cardiology, Houston.
Feb. 15-19—Amer. Acad. of Allergy, San Diego.
Feb. 21-28—Am. Soc. of Clinical Pathologists and College of Am. Pathologists, Las Vegas.

JUST

a brief reminder that the Wheeling Clinic's Golden Jubilee Scientific Seminar is the 18th and 19th of this month at Oglebay Park in Wheeling. 232-3600

WVU Medical Center
–News–

• Compiled from material furnished by Mrs. Mary Ellin Wylie, Director, Medical Center News and Information Services, Morgantown, W. Va.

DR. Richard B. Knapp is the new Chairman of the Department of Anesthesiology at West Virginia University School of Medicine and Chief of the Anesthesiology Service at University Hospital.

Announcement of Doctor Knapp's appointment, which was effective July 1, was made by WVU President James G. Harlow.

A native of New York, Doctor Knapp received his B. A. degree from Columbia College and his M. D. degree from New York Medical College. His internship was served at Memorial Hospital in Johnstown, Pennsylvania, and his residency at the New York Hospital of Cornell Medical Center.

He comes to WVU from New York Medical College, where he was Associate Clinical Professor of Anesthesiology. During this time, he also served as Attending Anesthesiologist at the Greenwich (Connecticut) Hospital.

His previous teaching and clinical experience includes service as an Instructor in Anesthesiology at Cornell Medical College, as Assistant Anesthesiologist-In-Chief at the United States Naval Hospital in Portsmouth, Virginia, and as Associate Anesthesiologist at the Guthrie Clinic, Robert Packer Hospital, Sayre, Pennsylvania.

He is a Diplomate of the National Board of Medical Examiners and the American Board of Anesthesiology and a Fellow of the American College of Anesthesiologists and the American College of Chest Physicians.

A member of the New York Academy of Sciences, the American Medical Association, the American Society of Anesthesiologists and the International Anesthesia Research Society, he also was Director of the Community Cardiopulmonary Teaching Program of the Greenwich Health Association.

Recipient of several research grants from the United States Public Health Service and pharmaceutical laboratories, he has published more than 20 scientific papers. His primary field of research is the investigation of pharmacologic agents related to both premedication and the induction of anesthesia.

Dr. William A. Neal Joins Pediatrics

Dr. William A. Neal, a native of Huntington and a graduate of the West Virginia University School of Medicine, has been appointed as Assistant Professor in the Department of Pediatrics at that school.

Doctor Neal, whose subspecialty qualifications include pediatric cardiology, will be primarily concerned with the organization of newborn intensive care at University Hospital.

Doctor Neal returns to WVU from the University of Minnesota, where he served his residency and was a medical Fellow in pediatric cardiology and an instructor in the Department of Pediatrics.

Graduating from the WVU School of Medicine in 1966, he served an internship at Milwaukee County General Hospital, spent three years at the Naval Aerospace Medical Institute in Pensacola, Florida, and was a flight surgeon on the USS Constellation before going to Minnesota.

A Diplomate of the National Board of Medical Examiners and the American Board of Pediatrics, he is the author or co-author of 12 publications detailing his research and experience particularly in the field of cardiovascular defects in children.

'Hotline' Service Has Problem

"Help Hotline," inaugurated at West Virginia University Hospital last October to help alleviate problems of patients and staff, has a problem of its own.

"The service just isn't being used enough to justify the cost of the telephone bill," said Don Killen, Director of the Social Service Department at the hospital.

Killen doesn't think patients and their relatives have fewer problems; he just feels that many are unaware of the Hotline service available to them.

"In the first month of operation, we had more than 20 calls," he said, "but they've dwindled to around 10 per month since then. I think people need to be reminded that this service is still offered to them."

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The Month in Washington

• **From the Washington Office of the American Medical Association.**

CONGRESS'S on-again-off-again attempt to write a national health insurance law are very much off again — so far off that most observers believe there is no chance whatsoever for the 93rd Congress to go down in history as the author of mandated health insurance for all.

The method of financing NHI was again the stumbling block, cutting the House Ways and Means Committee down the middle in a 12 to 12 vote (a tie vote defeats an amendment) and thus scuttled a patchwork proposal by Chairman Mills that seemed to many likely to win Committee passage.

The dramatic tie vote came about the morning of Tuesday, August 20, after the Committee had been called to order by Chairman Mills with the admonishment, "We need to work awfully hard."

Staff began to explain the draft compromise point by point in routine fashion to the Committee when Rep. Joel T. Broyhill, (R.-Va.) said he believed the Committee should be given the opportunity to vote on alternate methods of financing NHI (as opposed to the Social Security payroll tax) such as the tax credit idea in the AMA Medicredit plan. Mills stalled Broyhill off until the financing section of the compromise regarding mandated employer coverage was completed. The Chairman was about to go on, when Broyhill again reminded Mills that he wanted a vote on his amendment. The AMA tax credit approach would be voluntary and consistent with the free enterprise system, Broyhill said.

The first roll call vote of the Committee defeated the Broyhill proposal 11 to 10. One member — Rep. Bill Archer (R.-Texas), — changed his vote from "present" to "aye" and the motion was tied. Rep. Charles Chamberlain, (R.-Mich.), walked in and the proposal was ahead 12-11. However, Rep. Herman Schneebeli, (R.-Pa.), showed up to cast a "no" vote and the tie 12-12 tally defeated the Broyhill proposal.

Though not apparent at the time, this was the beginning of the end. Rep. Omar Burleson, (D.-Texas), lost 13-12 on his bid to substitute the financing proposed by the health insurance industry's NHI plan. The crusher came at the afternoon session when the Committee approved 11 to 7 a motion to make voluntary rather than mandatory the compromise provision for the poor and the self-employed.

The following morning shortly after the Committee had convened, Chairman Mills threw up his hands, saying: "I've never tried harder on anything in my life. But we don't have it. I'm not going to go before the House with a NHI bill approved by any 13-12 vote." He said the staff should try to figure out a different approach, but indicated he believed chances of reaching a future agreement on NHI were dim.

The forced abandonment of his compromise plan was a bitter defeat for Mills and for the Administration which had been working closely with the Chairman to steer a measure through the Committee. President Ford had urged Congress to give NHI top priority this year.

The up and down fortunes of NHI, which appeared to have a bright chance of passage following Ford's plea and Mills determined push for a compromise, have now slumped to the point where only some drastic intervention by President Ford could save the measure for this year.

Good News For Physicians

The House and Senate have passed and sent to the White House a liberalization of the Keogh law providing tax deferrals on retirement savings of self-employed people.

This means that physicians in this category can immediately start setting aside more money subject to tax deductions in qualified retirement programs. The bill's Keogh plan arrangement is retroactive to July 1, 1974.

(President Ford took time off on Labor Day to sign the bill into law).

The bill substantially boosts the savings subject to tax deductions. The present Keogh plan allows the self-employed to set aside tax free up to 10 per cent of their annual income with a $2,500 a year maximum. The new law will allow 15 per cent of earned income not to exceed $7,500 a year.

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Obituaries

RAY M. BOBBITT, M. D.

Dr. Ray M. Bobbitt, Huntington urologist and President of the West Virginia State Medical Association in 1939-40, died on August 18. He was 81. Doctor Bobbitt was a member of the State Medical Association's Council for two terms and was its Chairman in 1940-41.

A native of Hinton, he attended West Virginia University and received his M. D. degree in 1913 from the University of Maryland School of Medicine.

Ray M. Bobbitt, M. D.

Doctor Bobbitt interned at Sheltering Arms Hospital at Hansford and at Huntington State Hospital. He did postgraduate work at Johns Hopkins University School of Medicine. He was certified by the American Board of Urology and was a Fellow of the American College of Surgeons, the American Urological Association, the International College of Surgeons and the International Urological Association.

Doctor Bobbitt, a former member of the Huntington City Council, was an honorary member of the Cabell County Medical Society and formerly had served as Treasurer of the Society for eight years. He also was an honorary member of the West Virginia State Medical Association and the American Medical Association.

Doctor Bobbitt was a member and Past Chairman of the Southern Medical Urological Association. He was a recipient of the annual meritorious service award of the West Virginia Public Health Association for his help in organizing the Cabell-Huntington Health Department.

He served for two years with the U. S. Army Medical Service during World War I.

Survivors include the widow; a son, Dr. John M. Bobbitt of Huntington; two daughters, Mrs. Thomas Wolfe and Mrs. George J. McTigue, both of Washington, D. C., and a step-daughter, Mrs. Jacquelyn Craft of Huntington.

W. W. ORR, M. D.

Dr. W. W. Orr of Rachel, in Marion County, died on July 30 at his home. He was 90.

A family physician, Doctor Orr was born in Independence, in Preston County. Except for the years he served as Captain in The U. S. Medical Corps during World War I, he spent his entire medical career in Rachel.

Doctor Orr attended Sewanee College in Tennessee and graduated from Valparaiso College in Illinois. He received his M. D. degree in 1912 from Loyola University Stritch School of Medicine and served his internship and residency at Grace Hospital in Chicago.

Doctor Orr was an honorary member and a Past President of the Marion County Medical Society, and an honorary member of the West Virginia State Medical Association and the American Medical Association.

Survivors include the widow, a daughter, Mrs. Jacqueline Lindbeck of Bowie, Maryland; a foster daughter, Irene Moore, at home, and three sons, Edwin Orr of Memphis, Tennessee, Homer Orr of Fairmont and Harris Orr at home.

FRANCIS M. KIVLAHAN, M. D.

Dr. Francis M. (Frank) Kivlahan, an anesthesiologist on the staffs of the Wheeling Hospital and the Ohio Valley Medical Center, died on August 20 at his home. He was 44.

Born in Belfast, Ireland, he graduated from Queens University Medical School in Belfast and served his internship in Coleraine and Belfast. Upon arriving in the United States in 1957, he practiced general medicine and anesthesiology in Hartford, Connecticut before coming to Wheeling in 1965.

Doctor Kivlahan was a member of the Ohio County Medical Society, the West Virginia State Medical Association and the American Medical Association.

Survivors include his father, Patrick Kivlahan of Belfast; two daughters, Eileen and Kathleen Kivlahan, and two sons, Patrick and Kevin Kivlahan, all of Wheeling; one sister, Mrs. Kathleen Matesic of Toronto, Canada, and two brothers, Patrick Kivlahan of Toronto and John Kivlahan of Belfast.

RICHARD B. SHERIDAN, M. D.

Dr. Richard B. Sheridan of Vienna, a surgeon, died on August 13 in a Parkersburg hospital. He was 59.

A native of Pennsylvania, he came to Parkersburg in 1944 as an associate of the late Dr. Thomas L. Harris. He was a graduate of Lafayette College and received his M. D. degree in 1941 from Yale University School of Medicine.

Survivors include the widow, two sons, Richard B. Sheridan, III, and David C. Sheridan, both of Vienna; two brothers, Michael H. Sheridan of Wilkes Barre, Pennsylvania and Thomas B. Sheridan of Parsippany, New Jersey, and one sister, Miss Harriett M. Sheridan of Washington, D. C.

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Resolutions

Your Committee on Resolutions has carefully considered the resolutions offered at the first session of the House of Delegates on Wednesday afternoon, August 21, 1974.

We are happy to report that a number of interested physicians appeared at a meeting of the Committee held on Thursday afternoon, August 22, 1974, and discussed in detail the resolutions pending before the Committee.

The cooperation of those physicians present was most helpful to the Committee in reaching decisions, and we express appreciation to those who took time to attend the open hearings.

Mr. President, your Committee assures the members of the Association that the one and only consideration that has guided the Committee in its deliberations has been the criteria as to whether each of the resolutions were or would be to the best interests of the entire medical profession in West Virginia.

Mr. President, your Committee considered Resolution No. 1 pertaining to Statewide Unified Membership in the American Medical Association, which was offered by the Raleigh County Medical Society.

The Committee voted unanimously to recommend to the House of Delegates that Resolution No. 1 be referred to the Executive Committee for study and report back to the House of Delegates at the 1975 Annual Meeting.

Mr. President, your Committee talked at length about Resolution No. 2 pertaining to the Use and Acceptance of the Standard American Medical Association's Claim Form by Insurance Carriers doing Business in West Virginia, which was offered by the Monongalia County Medical Society.

The Committee voted unanimously to recommend the adoption of Resolution No. 2 as originally introduced.

Mr. President, your Committee discussed Resolution No. 3 in re Development of a Referral System to Assist Persons Desiring Medical Care or a Family Physician, which was offered by the Mercer County Medical Society.

Mr. President, your Committee voted to amend the resolving clause as follows: "THEREFORE, BE IT RESOLVED, That the West Virginia State Medical Association encourage its component medical societies to develop a satisfactory referral system to assist persons desiring medical care."

Mr. President, your Committee discussed at great length Resolution No. 4 in re Professional Standards Review Organizations, which was offered by the Kanawha Medical Society.

Mr. President, the Committee voted that the Resolution as originally introduced be not adopted and that the following substitute Resolution be adopted:

"BE IT RESOLVED, That the West Virginia State Medical Association notify the Secretary of Health, Education and Welfare of its intentions to press for corrective amendments to PL 92-603 to insure that the quality aspects assuring adequate high level care are enhanced; and

BE IT FURTHER RESOLVED, That the members of the West Virginia State Medical Association who are also members of the West Virginia Medical Institute, Inc., be advised to proceed carefully and cautiously in implementation of the present PSRO statute; and that the Institute proceed to develop and adopt a uniform, all-patient peer review system; and

BE IT FURTHER RESOLVED, That the Institute pursue all avenues of financial support, not Federal alone, to create an effective and unassailable peer review system; and

BE IT FURTHER RESOLVED, That the West Virginia State Medical Association recognize and honor the right of any of its members to elect nonparticipation in the current West Virginia PSRO plan."

Mr. President, your Committee discussed at length Resolution No. 5 pertaining to Medical Freedom for Miners, which was offered by the Kanawha Medical Society.

Mr. President, your Committee voted to recommend that the Resolution as introduced originally be not adopted and the following substitute Resolution be adopted:

"WHEREAS, The United Mine Workers Welfare and Retirement Fund is an agency funded by a royalty per ton of coal mined for the purpose of providing Welfare and Retirement benefits including medical care for the miners and their dependents; and

WHEREAS, The policy of the United Mine Workers Welfare and Retirement Fund is to establish a list of participating physicians for the purpose of maintaining financial control over expenditures; and

WHEREAS, The policy of United Mine Workers Welfare and Retirement Fund is to remove the names of participating physicians when there is a disagreement or conflict in medical or fiscal matters without the utilization of the grievance mechanisms established by the medical profession or the benefit of peer review; and

WHEREAS, The removal of participating physicians by the Area Administrator for UMW District 17 has interfered in the free choice of phy-

sicians and hospital facilities, as well as the normal doctor-patient relationship; and

WHEREAS, Such action has interfered with the availability of quality medical care within a reasonable distance of many beneficiaries; and

THEREFORE, BE IT RESOLVED, That the West Virginia State Medical Association enter into negotiations with the United Mine Workers Welfare and Retirement Fund in an attempt to terminate these activities; and

BE IT FURTHER RESOLVED, That, if these negotiations fail, the West Virginia State Medical Association condemn the United Mine Workers Welfare and Retirement Fund for the activities they are participating in which interfere in the private practice of medicine in the provision of continued quality medical care for their beneficiaries and totally disregard the established mechanisms for quality control in the name of economic responsibility; and

BE IT FURTHER RESOLVED, That the West Virginia State Medical Association make this censorship public and cite such activities as an example of what a third party which provides financial reimbursement for medical services can do by interfering in the provision of medical care to the jeopardy of the health of its beneficiaries."

Mr. President, your Committee considered Resolution No. 6 pertaining to the Crippled Children's Service Monopoly, which was offered by the Kanawha Medical Society.

Mr. President, the Committee voted unanimously to recommend that the resolving clause be amended to read as follows: "THEREFORE, BE IT RESOLVED, That the West Virginia State Medical Association request that the Commissioner of the West Virginia Department of Welfare meet with the Medical Economics Committee of the Association to consider these matters."

Mr. President, your Committee considered Resolution No. 7 pertaining to State Agency Subsidizing, which was offered by the Kanawha Medical Society.

Mr. President, while your Committee agreed in principle with the Resolution, they voted unanimously to recommend that the Resolution not be adopted.

Mr. President, the Committee discussed Resolution No. 8 in re the Recommendation that the VOSAS Program be Continued by the West Virginia Medical Institute, Inc., which was offered by the Committee on Medical Education and Hospitals.

Mr. President, your Committee unanimously recommends that Resolution No. 8 be adopted as originally introduced.

Mr. President, your Committee considered Resolution No. 9 in re Endorsement of the Candidacy of Dr. Carl B. Hall for President Elect of the American Academy of Family Physicians, which was offered by the Council.

Mr. President, your Committee unanimously voted to not only adopt the Resolution as originally offered but also stressed the importance that friends of Doctor Hall contact colleagues in other states to enlist support for Doctor Hall's candidacy. (For the text of this resolution please see story in the general news section of this issue of *The Journal*).

Mr. President, your Committee discussed Resolution No. 10 pertaining to Opposition to Any Law in West Virginia Allowing Abortion upon Demand, which was offered by the Hancock County Medical Society.

Mr. President, the Committee voted unanimously that the Resolution be not adopted.

Mr. President, the Committee unanimously recommended that the Resolution on this subject adopted by the American Medical Association in 1970, approved by the Council of the West Virginia State Medical Association in 1971, and reaffirmed by the House of Delegates of the West Virginia State Medical Association in 1972 be approved. The initial resolution reads as follows:

"WHEREAS, Abortion, like any other medical procedure, should not be performed when contrary to the best interests of the patient since good medical practice requires due consideration for the patient's welfare and not mere acquiescence to the patient's demand; and

WHEREAS, The standards of sound clinical judgment, which, together with informed patient consent should be determinative according to merits of each individual case; therefore be it

RESOLVED, That abortion is a medical procedure and should be performed only by a duly licensed physician and surgeon in an accredited hospital acting only after consultation with two other physicians chosen because of their professional competency and in conformance with standards of good medical practice and the Medical Practice Act of his State; and be it further

RESOLVED, That no physician or other professional personnel shall be compelled to perform any act which violates his good medical judgment. Neither physician, hospital, nor hospital personnel shall be required to perform any act violative of personally-held moral principles. In these circumstances good medical practice requires only that the physician or other professional personnel withdraw from the case so long as the withdrawal is consistent with good medical practice."

Mr. President, your Committee discussed Resolution No. 11 pertaining to the Endorsement of Judicial Reorganization Amendment, which was offered by the Council.

Mr. President, I move the adoption of the Resolution.

Mr. President, your Committee considered Resolution No. 12 in re Unilaterally Established Schedule of Maximum Allowances by Insurance companies, which was offered by the Council.

Mr. President, I move the adoption of the Resolution.

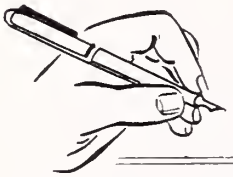
Mr. President, we wish to thank the members of the West Virginia State Medical Association who appeared before the Committee at the open hearing on Thursday afternoon, August 22, 1974.

Your Chairman personally expresses his gratitude to the members of the Committee for their patience, enthusiasm, wisdom and valuable time devoted to the study of the resolutions. In addition to your Chairman, the members of the Committee participating were Drs. George R. Callender, Jr., of Charleston; Worthy W. McKinney of Beckley; L. J. Pace of Princeton; and Harry S. Weeks, Jr., of Wheeling; and Mr. William H. Lively, Mr. Custer B. Holliday and Mr. Charles R. Lewis, members of the staff.

Respectfully submitted,

Richard E. Flood, M.D.
Chairman

White Sulphur Springs,
August 24, 1974.



Our Readers Speak

(Continued from Page 267)

with a venereal disease without knowledge and consent of the minor's parent or guardian."

In addition to the so-called epidemiologic treatment of venereal disease — treatment on history of contact without waiting for the development of pathology — we urge more efforts at diagnosis. It is estimated that the large majority of females with gonorrhea are asymptomatic. Routine culture with transgrow culture media will identify many of these.

Less than 100 cases of early syphilis per year are reported; but the Bureau of Venereal Disease Control of the West Virginia State Department of Health is prepared to perform darkfield examinations over the entire State.

We ask for your help in controlling this epidemic and pledge you not only our cooperation but any other assistance for which you might ask. Early diagnosis, prompt reporting and epidemiologic treatment are all necessary to curb this scourge.

W. L. Cooke, M.D.
Director Division of Disease Control
State Department of Health
Charleston, W. Va. 25305

Necrology Report

The following is a list of West Virginia physicians whose deaths have been reported to the West Virginia State Medical Association during the past year:

1973

July	4—John S. Boling	Lubbock, Texas
Sept.	16—R. D. Harman	Howey-in-the-Hills, Fla.
Sept.	20—Frank M. Muldoon	Salem
Sept.	28—Diego Nunnari	Oak Hill
Oct.	5—Thurman E. Voss	Bluefield
Oct.	8—Samuel J. Ferguson	Huntington
Oct.	17—Thomas B. Baer	Bluefield
Oct.	19—A. W. Milhoan	Nitro
Nov.	12—A. David Belton	Beckley
Dec.	6—John J. Sherman	Martin, Kentucky
Dec.	7—Herschel R. Yost	Fairmont
Dec.	10—Frank P. Eves	Beckley
Dec.	13—W. H. Price	Williamson
Dec.	31—William T. Gocke	Miami, Fla.

1974

Jan.	1—Charles A. Jones	Clarksburg
Jan.	9—J. J. Jenkins	Farmington
Jan.	11—John O. Theiss	New Martinsville
Jan.	13—A. B. Carr	War
Jan.	16—Frederick D. Keller	Belpre, Ohio
Feb.	1—S. B. Souleyret	Cabin Creek
Feb.	5—A. Morgan Dearman	Parkersburg
Feb.	9—Ross P. Daniel	Beckley
Feb.	18—W. S. Rowan	Logan
Feb.	19—Glenn Ashworth	Buckhannon
Feb.	21—Francis A. Scott	Huntington
Feb.	25—James E. Grace	Chelyan
Feb.	28—I. W. Taylor	Ft. Lauderdale, Fla.
Mar.	3—Malcolm G. MacAulay	Beckley
Mar.	14—Isadore Erwin Buff	Charleston
Apr.	1—Bernard W. Wilkinson	Clarksburg
Apr.	18—John M. Brown	Shinnston
Apr.	22—Arthur A. Shawkey	Charleston
Apr.	24—J. Brennan Purkall, Jr.	Bluefield
Apr.	30—R. O. Halloran	Charleston
June	23—Robert E. Baer	South Charleston
July	30—W. W. Orr	Rachel
Aug.	18—Ray M. Bobbitt	Huntington
Aug.	20—Francis M. Kivlahan	Wheeling

Respectfully submitted,
William H. Lively,
Executive Secretary

August 21, 1974

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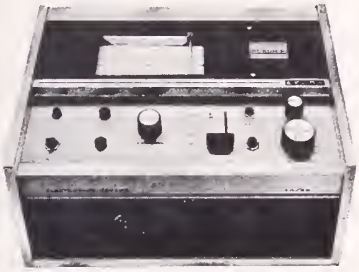

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Brooke	John W. Traubert	Wellsburg	James E. Wise	Follansbee	
Cabell	E. J. Humphrey, III	Huntington	C. H. McKown, Jr.	Huntington	2nd Thurs.
Central West Virginia	I Frank Hartman, II	Buckhannon	Joseph B. Reed	Buckhannon	As Sched.
Eastern Panhandle	Hiram Sizemore, Jr.	Shepherdstown	Everett S. Fogle	Martinsburg	2nd Wed.
Fayette	A. R. Bautista	Montgomery	Carl R. Adkins	Fayetteville	1st Wed.
Greenbrier Valley	Lee B. Todd	Quinwood	Harold P. Dinsmore	Ronceverte	2nd Wed.
Hancock	Dominic A. Brancazio	Weirton	James M. Garvey	Weirton	3rd Tues.
Harrison	Mehmet V. Kalaycioglu	Shinnston	Julian D. Gasataya	Lumberport	1st Thurs.
Kanawha	John B. Markey	Charleston	Joseph T. Skaggs	Charleston	2nd Tues.
Logan	Mark S. Spurlock	Logan	Jorge J. San Pedro	Man	2nd Wed.
Marion	Robert G. Janes	Fairmont	Mary Jordan	Fairmont	Last Tues.
Marshall	Andrew J. Barger	Glen Dale	Michail Dolgovskij	Glen Dale	3rd Tues.
Mason	Aarom Boonsue	Pt. Pleasant	Anthony G. Sola	Pt. Pleasant	4th Tues.
McDowell	Mario S. Cardona	Welch	A. A. Carr	Welch	2nd Wed.
Mercer	Hawey A. Wells, Jr.	Princeton	John J. Mahood	Bluefield	3rd Mon.
Mingo	Charles H. Bruce	Williamson	Wm. H. Carter	Williamson	2nd Wed.
Monongalia	W. Gene Klingberg	Morgantown	H. Summers Harrison	Morgantown	1st Tues.
Ohio	Joseph N. Aceto	Wheeling	Edward C. Voss, Jr.	Wheeling	4th Tues.
Parkersburg Academy	R. J. Bailey	Parkersburg	Paul G. Modie, Jr.	Parkersburg	1st Thurs.
Potomac Valley	Estevan Friera	Romney	Carl A. Liebig	Keyser	2nd Wed.
Preston	Donald P. Brown	Kingwood	C. Y. Moser	Kingwood	4th Thurs.
Raleigh	Eugene Warvariv	Daniels	C. W. Nelson, Jr.	Beckley	3rd Thurs.
Summers	Davis Wm. Ritter	Hinton	James Wm. Stokes	Hinton	3rd Mon.
Tygart's Valley	Robert R. Rector	Elkins	A. Kyle Bush	Philippi	3rd Thurs.
Wetzel	Lemoyne Coffield	N. Martinsville	Charles P. Watson	N. Martinsville	Monthly
Wyoming	Solomon D. Reodica	Mullens	Jose Floresca	Mullens	Quarterly

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Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, allergy or bronchial asthma; and in those with glucose-6-phosphate dehydrogenase deficiency, where hemolysis may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

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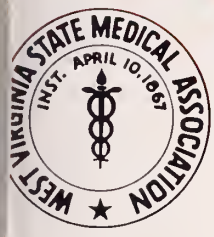

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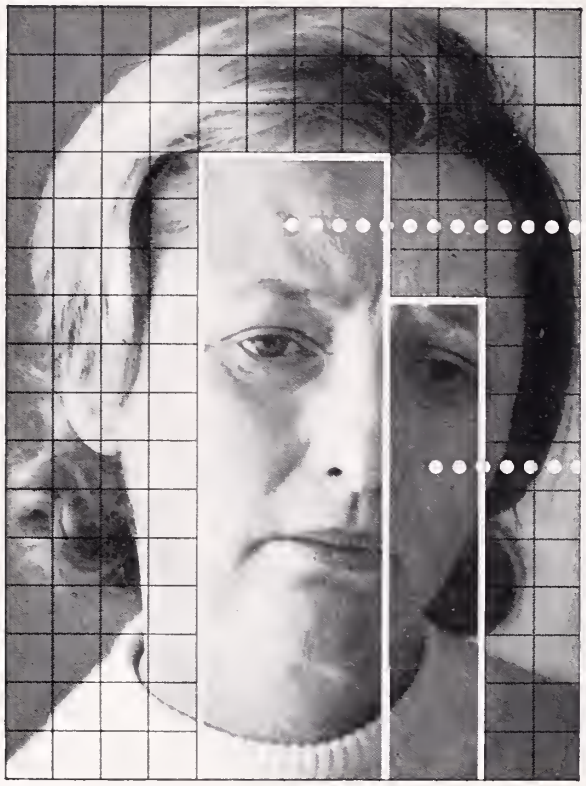

Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in and/or severity of grand mal se require increased dosage of star convulsant medication; abrupt w may be associated with tempora crease in frequency and/or seve seizures. Advise against simulta gestion of alcohol and other CNS sants. Withdrawal symptoms (si those with barbiturates and alco occurred following abrupt disco (convulsions, tremor, abdomina cle cramps, vomiting and sweati addiction-prone individuals unde

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two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

For further information on this subject, the following references are provided:

1. Henry BW, *et al: Dis Nerv Syst 30*:675-679, Oct 1969.
2. Hollister LE, *et al: Arch Gen Psychiatry 24*:273-278, Mar 1971.
3. Claghorn J: *Psychosomatics 11*:438-441, Sept-Oct 1970.

Valium®
(diazepam)

2-mg, 5-mg, 10-mg tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

because of their predisposi-
tuation and dependence. In
lactation or women of child-
, weigh potential benefit
sible hazard.

s: If combined with other psy-
or anticonvulsants, consider
armacology of agents em-
gs such as phenothiazines,
arbiturates, MAO inhibitors
ntidepressants may potentiate
sual precautions indicated in
erely depressed, or with latent
or with suicidal tendencies.

Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

NOVEMBER
1974

Vol. 70 No. 11

The
WEST VIRGINIA
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Member 1974

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Kids' Stuff

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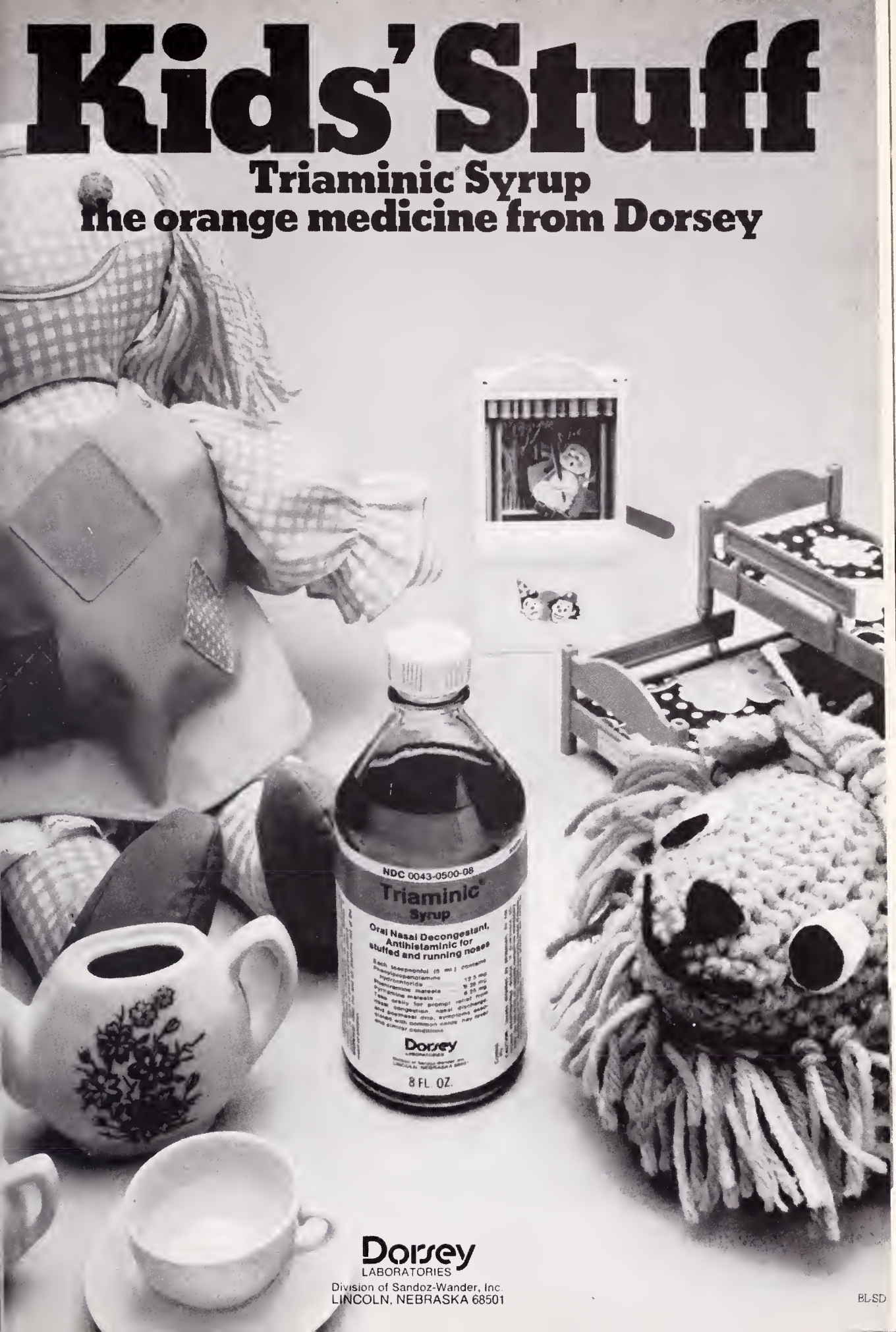
the orange medicine from Dorsey



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LINCOLN, NEBRASKA 68501

BL-SD

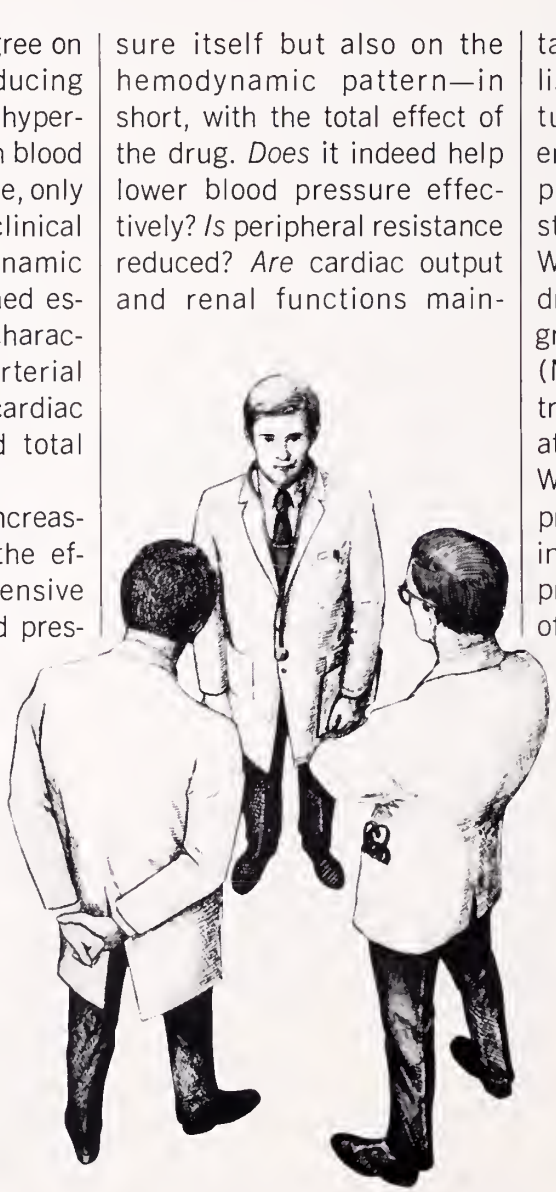
The more physicians consider the hemodynamics of lowering blood pressure...

Most physicians now agree on the importance of reducing blood pressure in the hypertensive patient. But high blood pressure exists, of course, only as part of a complete clinical picture. The hemodynamic profile of well-established essential hypertension is characterized by elevated arterial blood pressure, normal cardiac output, and increased total peripheral resistance.

And so, physicians are increasingly concerned with the effects of an antihypertensive agent not only on blood pressure itself but also on the hemodynamic pattern—in short, with the total effect of the drug. *Does* it indeed help lower blood pressure effectively? *Is* peripheral resistance reduced? *Are* cardiac output and renal functions maintained? And, also, is there likely to be drug-induced postural hypotension serious enough to pose a threat to the patient's cerebrovascular status?

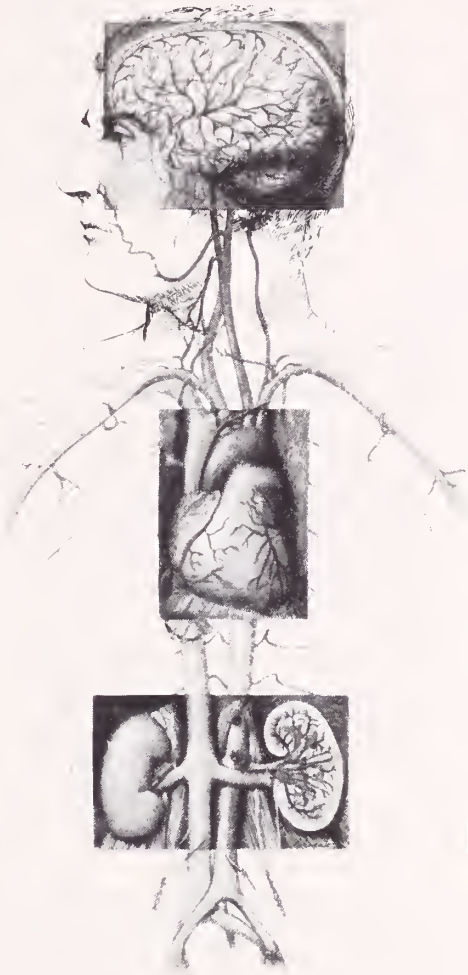
With this emphasis on overall drug performance has come a growing reliance on ALDOMET® (Methyldopa, MSD) in the treatment of sustained moderate hypertension.

With its unique hemodynamic profile, ALDOMET has drawn increasing attention and approval from physicians. First, of course, for its efficacy in



the more physicians rely on this unique antihypertensive

lowering blood pressure. But there are other considerations as well. Cardiac output is usually maintained with no cardiac acceleration; in some patients the heart rate is actually slowed. Peripheral resistance is apparently reduced. ALDOMET does not usually compromise existing renal function; it generally does not reduce renal blood flow, glomerular filtration rate, or filtration fraction. And ALDOMET usually does not cause symptomatic postural or exercise hypotension.



Contraindications include active hepatic disease and known sensitivity to the drug. Use with caution in patients with a history of liver disease or dysfunction. Not recommended in pheochromocytoma or pregnancy.

It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. For more details see the brief summary of prescribing information.

In most cases of sustained moderate hypertension

TABLETS, 250 mg and 500 mg

ALDOMET®

(METHYLDOPA | MSD)

smoothly lowers blood pressure

NEW now available in 500 mg TABLETS as well as the standard 250-mg tablets

For a brief summary of prescribing information, please see following page.

In most cases of sustained moderate hypertension

ALDOMET®
(METHYLDOPA MSD)

smoothly lowers blood pressure

Contraindications: Active hepatic disease, such as acute hepatitis and active cirrhosis. Known sensitivity. Not recommended in pheochromocytoma. Unsuitable in mild or labile hypertension responsive to mild sedation or thiazide therapy. Use cautiously in patients with history of previous liver disease or dysfunction.

Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between six and twelve months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at six and twelve months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first three weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first two to three months of therapy. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first six to twelve weeks of therapy or whenever an unexplained fever occurs. If fever, abnormalities in liver function tests, or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, reversible reduction in leukocyte count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur.

Use in Pregnancy and Childbearing Age—Not recommended in pregnancy. In women of childbearing age, weigh potential benefits against possible fetal hazards.

Precautions: Methyldopa may interfere with measurement of: uric acid by the phosphotungstate method, creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, spuriously high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has occurred after dialysis in patients on methyldopa because the drug is removed by this procedure.

Adverse Reactions: Sedation, usually transient, may be seen during initial therapy or when dosage is increased. Headache, asthenia, or weakness may be noted as early, transient symptoms. Symptoms associated with effective lowering of blood pressure are occasionally seen and include dizziness, lightheadedness, and symptoms of cerebrovascular insufficiency. Angina pectoris may be aggravated. Symptoms of orthostatic hypotension may occur; if symptoms occur, reduction of dosage is suggested. Bradycardia, nasal stuffiness, mild dryness of mouth, and gastrointestinal symptoms including distention, constipation, flatus, and diarrhea occur occasionally; these generally can be relieved by reducing dosage. Nausea and vomiting have been reported in only a few patients. Sore tongue or "black tongue," pancreatitis, and inflammation of salivary glands may occur.

Weight gain and edema occur infrequently and are relieved by administering a thiazide diuretic; if edema progresses or signs of pulmonary congestion appear, discontinue drug. A rise in BUN has been observed. Other rare reactions include breast enlargement, lactation, impotence, decreased libido, skin rash, mild arthralgia, myalgia, paresthesias, Bell's palsy, parkinsonism, psychic disturbances including nightmares, reversible mild psychoses or depression. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Note: Dosage should be limited initially to 500 mg daily when following previous antihypertensive agents other than thiazides. Maximal recommended daily dose is 3.0 g. Patients with impaired renal function may respond to smaller doses than patients with normal kidney function. Syncope in older patients has been related to increased sensitivity in those with advanced arteriosclerotic vascular disease; this may be avoided by lower doses. Tolerance occasionally seen either early or late, but more likely between second and third month after initiation of therapy; increased dosage or combined therapy with a thiazide frequently restores effective control.

How Supplied: Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000; Tablets, containing 500 mg methyldopa each, in single-unit packages of 100 and bottles of 100.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

addendum

"Required Reading" For Your Hypertensive Patients

Because of the importance of patient motivation, Merck Sharp & Dohme offers "High Blood Pressure," a concise, pocket-sized booklet that defines the patient's own role in the management of hypertension. This booklet is available for you to give to your patients. It is designed to reinforce your explanation of hypertension and it emphasize the importance of patient understanding in adhering to the regimen you prescribe.

Please ask your Merck Sharp & Dohme Professional Representative or write Professional Service Department, West Point, Pa. 19486 for a supply of this booklet.

A half-ounce of prevention

Use it to prevent a topical infection. Or to treat one that's already started. In either case, it's good medicine. Whether for lacerations, burns, open wounds, IV catheter or surgical aftercare. Neosporin® Ointment provides broad antibacterial coverage against common susceptible pathogens. And since it contains three antibiotics that are rarely used systemically, the risk of sensitization is reduced. Neosporin Ointment. A half-ounce of prevention. Also available in a full ounce of prevention and in convenient foil packets.

Neosporin Ointment carried on Apollo and Skylab missions.

Neosporin® Ointment
(polymyxin B-bacitracin-neomycin)

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs.
In tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

CATIONS: *Therapeutically*, used as an adjunct to appropriate systemic apy for topical infections, primary or secondary, due to susceptible organ-, as in: • infected burns, skin grafts, surgical incisions, otitis externa mary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • second-ly infected dermatoses (eczema, herpes, and seborrheic dermatitis) umatic lesions, inflamed or suppurating as a result of bacterial infection. *rophylactically*, the ointment may be used to prevent bacterial contamination urns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts wounds accidentally incurred, its use may prevent the development of ction and permit wound healing.

TRAINDICATIONS: Not for use in the eyes or external ear canal if the eardrum erforated. This product is contraindicated in those individuals who have n hypersensitivity to any of the components.

NING: Because of the potential hazard of nephrotoxicity and ototoxicity to neomycin, care should be exercised when using this product in treating nsive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

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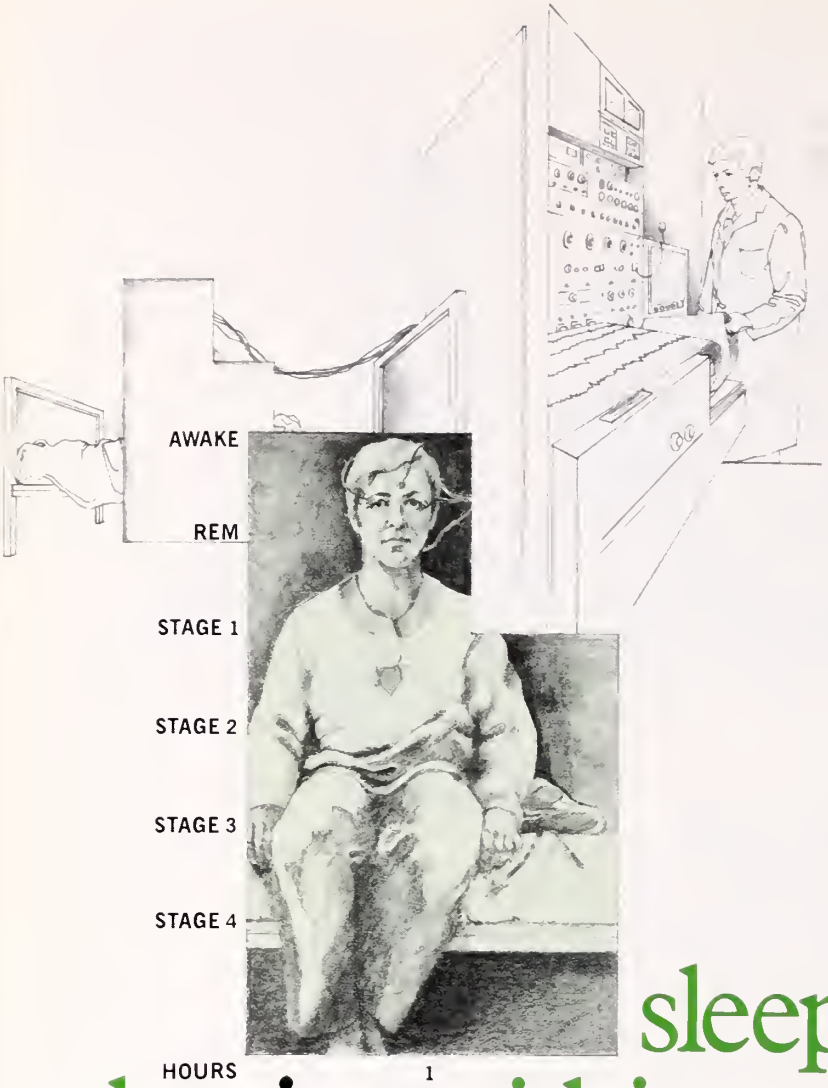


sleep begins within 17 minutes, on average ...

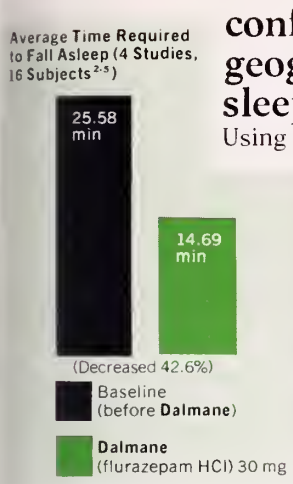
an initial benefit of

Dalmane®

(flurazepam HCl)

proved by a 22-night clinical study of insomnia patients in the sleep research laboratory and at home[1]

Three insomnia patients selected for difficulty falling asleep were administered Dalmane (flurazepam HCl) 30 mg for 14 consecutive nights. Placebo was given for four nights prior to and four nights after Dalmane. Physiologic tracings on Dalmane nights 1-3 showed sleep induction time averaged 13.90 minutes; on Dalmane nights 12-14, 18.80 minutes. Combined average for the 6 monitored drug nights was 16.35 minutes.[1]



confirmed by clinical studies in four geographically separated sleep research laboratories[2-5]

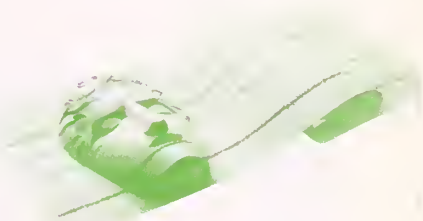
Using a 14-night protocol involving eight insomniac and eight normal subjects, four studies confirmed the sleep-inducing effectiveness of Dalmane (flurazepam HCl) and the reproducibility of this response. On average, one 30-mg capsule induced sleep within 17 minutes. In all these studies, Dalmane induced sleep rapidly, reduced nighttime awakenings, and provided 7 to 8 hours of sleep without repeating dosage[2-5]

Dalmane (flurazepam HCl) induces and maintains sleep, with relative safety

Dalmane is generally well tolerated; morning "hang-over" has been relatively infrequent. While dizziness, drowsiness, lightheadedness and the like have been noted most often, particularly in the elderly and debilitated, physicians should be aware of the possibility of more serious reactions, as noted below.

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.
Contraindications: Known hypersensitivity to flurazepam HCl.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.
Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.
Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.
Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.
Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.



when restful sleep is indicated

Dalmane®
(flurazepam HCl)

One 30-mg capsule *h.s.* — usual adult dosage (15 mg may suffice in some patients).
One 15-mg capsule *h.s.* — initial dosage for elderly or debilitated patients.

- induces sleep within 17 minutes, on average
- reduces nighttime awakenings
- sustains sleep 7 to 8 hours, on average, without repeating dosage

REFERENCES: 1. Kales A, *et al*: *Arch Gen Psychiatry 23*:226-232, Sep 1970
2. Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington DC, May 3-7, 1971
3. Frost JD Jr: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
4. Vogel GW: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ
5. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc, Nutley NJ

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Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

The Role of the Detail Man

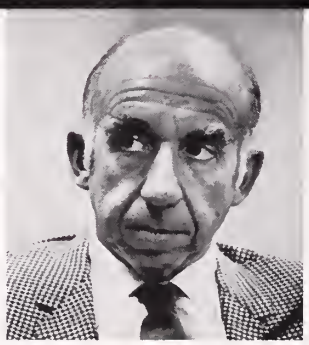
Opinion & Dialogue

Dr. Willard Gobbell
Family Physician
Encino, California

"I may be prejudiced, but I am very much in favor of the detail mer I meet. Most of them are knowledge able about the drugs they promote and can be a great help in acquainting me with new medication."

Family Physician's Perception

I think that most general practitioners in this area feel as I do about the detail man. Over the years I have gotten to know most of the men who visit me regularly and they in turn have become aware of my particular interests and the nature of my practice. They, therefore, limit their discussion as much as possible to the areas of interest to me. Since I usually see the same representative again in future visits, it is in his best interest to supply me with the most honest, factual, as well as up-to-date information about his products.



Dr. Jeremiah Stamler
Chairman
Department of Community Health and Preventive Medicine, and Dingman Professor of Cardiology
Northwestern University Medical School

"In the total picture of dealing with health problems in this country there is a potential for detail men to play a meaningful role."

The Positive Influence

My contact with representatives and salesmen of the pharmaceutical industry is the type of contact that people in a medical center, research people, and academic people have and that's in all likeliho on a somewhat different level from that of the practicing physician.

Let me touch on how I personally perceive the role of the sales representative. These men reach large numbers of health professionals. Thus they could be—and at times actually are—disseminators of useful information. They could consistently serve a real educational function in their ability to discuss their products.

At present they do distribute printed material, brochures and pamphlets—some of it scientifically sound and therefore truly useful—as well as some excellent films produced by the pharmaceutical industry. When they function in this

Ie a Source of Information?

Yes, with certain reservations. e average sales representative s a great fund of information out the drug products he is re- nsible for. He is usually able to swer most questions fully and elligently. He can also supply rints of articles that contain a at deal of information. Here, , I exercise some caution. I usu- accept most of the statements d opinions that I find in the ers and studies which come m the larger teaching facilities. oes without saying that a physi- n should also rely on other rces for his information on armacology.

ining of Sales Representatives

Ideally, a candidate for the sition as a sales representative a pharmaceutical company uld be a graduate pharmacist o has a questioning mind. I don't nk this is possible in every case, d so it becomes the responsibility of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

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pacity they are indeed useful; rticularly in the fact that they seminate broadly based educa- nal material and serve not just 'pushers" of their drugs.

e Other Side of the Coin

Obviously, the pharmaceuti- companies are not producing all s material as a labor of love— y are in the business of selling ducts for profit. In this regard ambitious and improperly moti- ed sales representative can rt a negative influence on the cticing physician, both by pre- ting a one-sided picture of his duct, and by encouraging the ctitioner to depend too heavily drugs for his total therapy. In se ways, the salesman has often torted objective reality and dermined his potential role as an ucator.

e Industry Responsibility

Since the detail man must be information resource as well as epresentative of his particular armaceutical company, he uld be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—*i.e.*, the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that information must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

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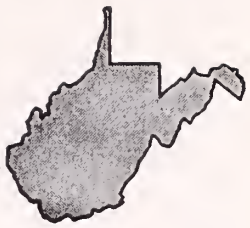
The West Virginia Medical Journal



Vol. 70, No. 11 November, 1974

Presidential Address*

A. Thomas McCoy, M. D.

The final draft of this speech was only written this morning, but in point of fact it has been written over the last year. I believe you will agree we had a most stimulating and provocative discussion in this room earlier today which convinced me that members of the Association do indeed have a close interest in the activities of this organization.

Dr. J. Hugh Wiley, who served as Chairman of the Program Committee for this the 107th Annual Meeting of the West Virginia State Medical Association, took upon himself to put together an open forum type of session which I believe was most enlightening.

Doctor Wiley and other leaders of the Association addressed themselves to the serious and challenging issues and I was impressed with the sincerity and intelligence — and yes, the candor of the several discussants.

The leadership of this or any other viable organization needs to be challenged by their membership. We must respond to your satisfaction or else we should be replaced. It's your organization — you are the boss — you are the best American medicine can produce right here in this audience and your organization should reflect that fact.

Activities of The Association

Let me tell you about your organization and what it is doing for you and your patients.

First of all in the field of *communications.* We do have an excellent publication — *"The West Virginia Medical Journal."* Although beset by many problems due to the necessity of finding another printer after the firm which had taken pride in publishing *The Journal* for many years was forced out of business, I am happy to report that everything is looking much better for *The Journal* than it did some six months ago. It has been quite a logistics prob-

The Author

- **A Thomas McCoy, M. D., Immediate Past President, West Virginia State Medical Association.**

A. Thomas McCoy, M. D.

*Presented at the second and final session of the House of Delegates, 107th Annual Meeting of the West Virginia State Medical Association, The Greenbrier, White Sulphur Springs, W. Va., Saturday, August 24, 1974.

lem but I'm informed almost all of them will be worked out shortly.

The West Virginia Medical Journal is a monthly publication containing scientific articles of general medical interest and most importantly a vehicle for the membership to communicate with each other through announcements concerning state, regional and national meetings — not to mention the ever-increasing number of continuing courses in medical education.

Editorials published in *The Journal* are frequently reprinted elsewhere which speaks well for the caliber of the members of the Publication Committee.

Yes, there also is a page given over to the President in each issue — and I have thoroughly enjoyed voicing personal opinions in this space and hope that at least a few of my messages have been read.

Medical Education

In the field of medical education, this meeting with the scientific and housekeeping duties incumbent upon any organization — plus the Mid-Winter Clinical Conference — are the organization's main endeavors in the field of continuing medical education. These are important responsibilities which your Association is happy to accept and we plan to continue to discharge them in a manner which will please you.

In addition to these two big educational conferences, we must also recognize and congratulate Dr. Pat A. Tuckwiller and the members of his hard-working Committee on Medical Education and Hospitals. In addition to reviewing our own educational programs, the Committee is the main accrediting body for all the educational programs planned by hospitals throughout the State.

The work of the Committee is not an easy chore but the members have done a wonderful job—not only this year but for many years in the past.

Dr. Tucker And The TRIP Program

The Association, as well as the citizens of West Virginia, owe many thanks to Dr. Eldon B. Tucker of Morgantown. Doctor Tucker has served as Chairman of our Committee on Aging for many years and was instrumental in sowing the seeds of the new Transportation Remuneration Incentive Program (TRIP).

Doctor Tucker put all his energy behind the establishment of TRIP which will help to reimburse our senior citizens for their transportation expenses. This is the first program of its kind in the country and this type of commitment and dedication is exactly what this Association is doing and plans to continue in the future.

Legislation

The field of legislation is a touchy subject but one in which we must become active and stay involved in now more than ever before. We should be particularly pleased with a couple of changes made in the insurance law which will now make it possible for our patients to know what benefits they can expect from their insurance policies before they enter hospitals seeking help for their illnesses.

We owe many thanks to the Insurance Commissioner — who with the help of our Legislative Committee and other interested groups, have been able to convince the Legislature to enact an insurance bill into law which may be regarded as a model for the rest of the country.

I would like to commend the Medical Licensing Board and the Legislature for changing the licensing law during the past session to make West Virginia a more attractive place for young physicians to practice and raise families.

The law has been changed so that our citizens will be assured that they will have access to the services of highly trained and qualified physicians. The law was amended to remove the citizenship requirement and those physicians who are board certified may now be licensed without passing an examination.

I shall be the first to admit the FLEX examination is difficult — even for some of the graduates of our American medical schools and especially for those foreign medical graduates now in residency training or practicing on temporary licenses under supervision of licensed physicians in the State. It is my belief, however, that we must preserve the highest quality medical care in West Virginia and almost — if not all—of the licensing boards in the United States have adopted the same type of licensing examination (FLEX). Therefore, we are not alone in making sure our patients receive treatment from physicians fully trained and capable of providing the best medical care possible.

Now, all of this just doesn't happen automatically. Dr. Frank J. Holroyd has served as Chairman of the Legislative Committee for a number of years and certainly his experience and dedication cannot be overlooked. It is important to remember that members of the Legislative Committee respond quickly to any words of advice Doctor Holroyd relays from messages

received almost daily from the headquarters office in Charleston—especially while the Legislature is in session. As you know, this has almost become a year-round proposition.

I personally want to thank each and every member of the Legislative Committee. These physicians are selected carefully and can be counted upon to go to work when help is needed at the Capitol in Charleston. It is no coincidence that we have a pretty good batting average in either promoting or opposing legislation which assures our citizens in the State of quality medical care.

Scholarships For Medical Students

I would now like to discuss briefly some other very important activities of the Association. For years we awarded four-year scholarships to two first-year students enrolled in the West Virginia University School of Medicine — which took a bite of $8,000 from the annual dues collected from our members.

In 1973 this House of Delegates voted to increase the number of scholarships from two to four — which in a couple of more years will mean the Association will be contributing $16,000 a year to 16 deserving medical students in Morgantown.

Let me tell you it's a most difficult job for our Medical Scholarships Committee to screen out just four from the large number of students who apply each year. The members of that important Committee deserve much praise for spending at least two days in Morgantown each Spring interviewing the applicants and I call this a dedicated piece of work. Furthermore, it is my understanding through the years that attendance by members of the Committee is almost always 100 per cent!

In the last 10 years we have experienced approximately a 70 per cent recovery rate of these scholarship recipients for the State of West Virginia. A few who have graduated are still in training and fulfilling service obligations which could even boost this figure. Seventy per cent of these young men and women are returning to West Virginia to practice medicine and I believe this is something the Association and you as members can look upon with a great deal of pride. It is my hope that our success in this endeavor will encourage other groups to establish similar programs.

AMA-ERF

Another way we help the School of Medicine each year is through our contributions to the AMA-ERF which also provides much needed assistance. We all realize, of course, that the real workers in this splendid cause are the members of our Woman's Auxiliary. They have given this project top priority through the years.

Medical Economics

I believe one of the most important responsibilities of this Association is to represent our members in negotiations with third-party agencies.

Let me assure you that this year the members of your Council received the most thorough, scholarly and thought-provoking presentations by the Chairman of the Medical Economics Committee, Dr. Carl J. Roncaglione. I don't know how many hours he must have spent in preparing these reports but let me be the first to say he is due a round of applause and tremendous amount of thanks for a job well done.

Professional Liability Insurance

There is no doubt one of the biggest problems we all face lies in the ever-present threat of medical liability claims.

Through our State Medical Association we are still able to purchase — admittedly rather costly — professional liability insurance. We have the ability and mechanism to review these law suits and determine how best to educate our physicians against ever being subjected to same.

I can look into the not too distant future and see how young physicians just completing their training might not be able to afford to pay the premium for this insurance. Ultimately this situation can mean that these physicians will elect to enter institutional rather than private practice.

Please be assured this matter is receiving the full attention of the Insurance Committee and Council and hopefully we will be successful in bringing about changes in the law to ease the problem.

West Virginia Medical Institute, Inc.

You will recall we discussed the West Virginia Medical Institute a bit frankly this morning. You probably know by now my own county medical society — in a well-worded and honestly conducted survey — voted overwhelmingly against the PSRO law. The results were a bit frightening.

But, we have to talk about the art of the possible. Like many have said — we don't like income taxes but we have to pay them. Few of us like the PSRO law. We believe it was one

of the worst pieces of legislation ever thrust upon the medical profession.

I do believe, however, that we have the mechanism within our own West Virginia Medical Institute to make the PSRO law work to the advantage of both physicians and our patients. It can and should be an educational tool where we will have an opportunity to review our work — see what we're doing well and what we are not doing so well.

I certainly don't want to put PSRO into the hands of the laity. It properly and of necessity must remain in the hands of professional groups. Personally, I would be most happy to have my own work reviewed by a competent practitioner in my specialty of urology — but never by an incompetent bureaucrat in Washington or elsewhere who would never be able to figure out what I am doing and why.

Then there is the matter of confidentiality. We have within the structure of the Institute an opportunity to make this PSRO law work. I don't believe for one minute that the responsibility of long periods of hospitalization lies solely with the physician. Inefficient hospital administration may prolong stay in hospitals and increase the physicians' waiting time unnecessarily.

I believe we can address ourselves to these matters if we maintain control of and monitor the activities of our own West Virginia Medical Institute.

Your Headquarters Staff

Before I conclude these remarks, I would be remiss if I didn't mention the fact that we have the finest headquarters staff of any state medical association in the country. How about that!

Our staff of four makes sure all of these things I have talked about are accomplished. You have Bill Lively and Custer Holliday—plus the two most competent gals you have ever known and who actually keep all of us on our toes—Mrs. Mary Hamilton and Mrs. Sue Shanklin.

I also don't want to forget Charlie Lewis, the Executive Director of the Institute, although he isn't regularly connected in any way with the Association. He was, however, a former full-time staff member before assuming the difficult task of making the Institute a reality while bucking difficult and frustrating obstacles along the way.

Anyway, our staff of four (which does the work of 20) takes care of the day-by-day activities of an Association composed of essentially 1,400 active members. I am sure you will agree they are due our heartfelt thanks and applause.

Directions for the Future

It is my earnest belief that we must create a mechanism within the Association to encourage our younger physicians to start moving up through the chairs of the organization at a faster pace.

This morning we heard Dr. John W. Traubert outline the new residency programs in family practice being implemented at two hospitals in the State, with a third to be established shortly. We have viable and excellent residency programs in almost all specialty groups in hospitals throughout the State.

We must make our State more attractive to these young physicians and their families. Also, we must make it possible for young physicians to talk with us and become active in the local, state and national medical organizations.

Your Duty As A Citizen

In conclusion, let me ask you a question. What have you done for your Association? Obviously you have worked hard in your local societies or else you wouldn't be representing your colleagues in this room on a lovely Summer afternoon when you could be outside enjoying everything this beautiful resort hotel has to offer in the way of recreational activities or just plain relaxing.

But what else are you doing for your Association? Not directly—but indirectly. How many of you are supporting or working for a candidate or candidates running for office in the November general election? How many of you are giving up your precious spare time to run for an elective public office How many of you are participating in affairs of government on the city or county levels?

We are living through a medical revolution and we are going to see more and more the active participation of the third parties in important medical decisions. It is in the best interest of our patients that these planning agencies and councils have a fair representation of physicians on their boards.

I have enjoyed serving as your President during the past year and sincerely appreciate the wonderful cooperation you have given me during my term of office.

Special Article

Pre-Hospital Coronary Care in West Virginia

William H. Carter, M.D.

A 60-year-old white male developed chest pain and collapsed in minutes while working in his yard in Charleston, West Virginia on May 14, 1974. A certified ambulance paramedic was summoned and he successfully defibrillated the patient. After a stormy few days which included several repeated episodes of ventricular fibrillation, the patient's course stabilized and he was discharged from the hospital on June 12, 1974, with only mild disability.

This was the first successful defibrillation of a cardiac victim by a certified paramedic in West Virginia. I shall discuss the history and development of pre-hospital coronary care worldwide in general and West Virginia in particular.

Coronary artery disease is reported to have caused 8,274 deaths in West Virginia in 1972, which represents 40 per cent of all deaths over the age of 45 for the year. From epidemiological data gathered elsewhere, it is reasonable to assume that over 50 per cent of patients dying of myocardial infarctions in West Virginia died within the first hour of developing chest pain. Younger patients tend even more to die suddenly. Moreover, a large percentage die not from a "massive heart attack" with shock or rupture, but rather from reversible ventricular fibrillation which commonly occurs early during even very small myocardial infarctions.[2-3]

Several approaches can reduce the mortality from sudden cardiac deaths: (1) Patients and physicians must appreciate the need to identify those patients about to have a myocardial infarction, i. e., those patients with new or instable angina. Prompt hospitalization probably reduces the incidence of myocardial infarction and certainly the ability to institute immediate drug and electrical therapy enhances the survival of a myocardial infarction if it occurs during hospitalization. (2) Provide means of early definitive care before the patient reaches the coronary care unit, especially in emergency rooms and ambulances. Transit times in urban areas is relatively short, but in rural areas such as present in West Virginia, the very fact that a patient did not fibrillate during the 30 to 60 minute ambulance ride to the hospital implies a good prognosis.

The Author

- **William H. Carter, M.D., Cardiologist, Charleston Area Medical Center, Charleston, W. Va.**

History of Mobile Coronary Care Units

Pantridge in Ireland first demonstrated that physicians in mobile vans could affect long-term survival from myocardial infarctions.[4] Specially trained paramedics and firemen have subsequently been able to achieve similar results in this country, not only in special "cardiac vans" but standard rescue vehicles used in other non-cardiac emergencies.[5] Thus, gradually the system has evolved in an economically feasible pre-hospital care system for many areas of the country. Still, however, most of the country has not developed an effective system for immediate care of the cardiac victim. *Subsequent discussion will concern efforts in West Virginia to provide definitive care for coronary care patients in the ambulances.*

Present Status of Pre-Hospital Coronary Care in West Virginia

In 1972, the West Virginia Legislature passed a bill (SB 281) which provided that paramedics certified by the State Health Department (designated as "Mobile Intensive Care Paramedics") may defibrillate pulseless patients and may administer IV fluids and certain medications if permission is verbally received (usually by radio) from a physician. At present, medications are limited to lidocaine, atropine, pentazocain (Talwin), and epinephrine. It is felt that these drugs have the greatest potential to save a patient during the first hour of a myocardial infarction and at the same time have the least potential to do harm.

Certainly other medications such as digitalis, pressor agents, isoproterinol (Isuprel), and morphine may on occasion be life-saving; however,

their toxicity would demand more extensive training. Transmission of the EKG by telemetry is not only expensive but technically difficult in mountainous terrain and is not required by the present State law. Areas where it is economically and technically feasible can, if so desired, use such systems.

State certification of ambulance personnel involve two levels of training that must be clearly distinguished. EMT's (emergency medical technicians) are certified after completion of the basic 80-hour course established by the American College of Orthopaedic Surgeons. Basic first-aid, cardiopulmonary resuscitation, splinting, and other trauma management are taught but EMT's are not, in contrast to mobile intensive care paramedics (MICP's), certified to defibrillate patients, start IV's, or give medications. MICP's are certified EMT's who then receive an additional minimum of 90 hours of training (30 hours of didactic lecture and 60 hours of in-hospital training) with an emphasis on cardiovascular physiology, arrhythmias, basic pharmacology and use of a defibrillator. Trainees who have not had previous U.S. military corpsmen training may require additional hours.

Training Considerations: MICP candidates are required to have a high school degree or an equivalent. For obvious reasons, veteran corpsmen have been particularly easy to train. Paid paramedics are preferred over volunteers since experience has demonstrated better attendance records during the courses, although certain highly motivated rescue squads could be trained. The present 90 hours of required training represents minimum requirements. Many trainees may require longer training. Possibly future training requirements will be increased. As of May 1974, 100 paramedics have been trained locally at Charleston, Huntington, Bluefield and Beckley, and all have passed state examinations.

Classes for MICP's may be given on local or regional levels. Course outlines are provided by the State Health Department. Since replacements are frequently needed from year to year, retraining a few paramedics would strain the medical education resources of many communities. The Area Health Education Center (AHEC) of the Charleston Area Medical Center started continual classes for both EMT's and MICP's in January 1974. Thus, small communities may have a few paramedics trained without requiring the organization of a 90-hour course. Possibly community colleges may play a similar role in the future.

The State Health Department approves the curriculum planned for a paramedic course, then tests and certifies those paramedics passing the tests. Our experience indicates poor retention of the MICP curriculum unless the community has an ambulance system ready for prompt application of their knowledge. Retesting will be required at specified intervals.

Local physicians must work closely with paramedics regardless of where they are trained in order to assure success, and in Charleston MD's meet weekly with paramedics during the first six months of the operation and will meet at specified intervals following that. Continual education of new paramedic "interns" is vital. All cases monitored each week are discussed with the physicians to assure that the entire paramedic group obtains maximum education from each case.

Full-time emergency room physicians at Charleston Area Medical Center at present provide immediate verbal communications with paramedics. Backup is also provided on an almost 24-hour basis by a physician especially interested in emergency medicine, Dr. Frederick M. Cooley, who carries a portable transmitter. It is possible this latter system could be used exclusively in locations where full-time coverage of emergency room physicians cannot be arranged.

Role of State Organizations

(1) The West Virginia State Medical Association initially was instrumental in lobbying for passage of ambulance legislation. The State Medical Association has served as a forum for communication between MD's interested in emergency health care. State level education conferences have already been sponsored with the State Health Department to upgrade physician education and emergency health care. Most important, local medical societies will need to provide needed manpower for initial education and continuing paramedic education once an emergency system is instituted.

(2) The State Health Department in West Virginia provided initial research into the legislation and the practical mechanics of other states' systems of ambulance pre-coronary care. Training materials and education expertise has been provided by the State to localities. A regional training program has been implemented in conjunction with the AHEC at the Charleston Area Medical Center as mentioned previously. Finally, the certification and recertification of

paramedics will be the responsibility of the State Health Department.

(3) Local governments, either county or city, must provide funds for ambulances, paid paramedics and specialized cardiac equipment. These funds may come from general revenue funds such as is the case in Charleston, or obtained from special federal funding such as had been done in the Southern part of the State through the Appalachian Regional Commission (ARC). The development of relatively light, portable, battery-operated defibrillators and electrocardiograms have enabled standard rescue vans to be equipped for basic coronary care for an approximate additional $4,000 per van. The greatest expense involves personnel; however, other areas unable to pay full-time paramedics already have trained existing public servants, such as firemen and policemen.

(4) The Heart Association, like the medical association, may provide a means of statewide communication for interested physicians; or lay education which stresses warning signs of infarction would decrease patient delay in coming under definitive care. Finally, mass training of lay personnel and CPR may be undertaken, such as has been provided in Seattle, Washington, where by 1973, 40,000 lay people had been instructed in cardiopulmonary resuscitation. This experience suggests that even less than maximally effective CPR by lay people could provide enough cerebral blood flow to prevent irreversible brain damage during the few minutes before definitive care arrives. In Charleston just prior to publication a 43-year-old male in ventricular fibrillation received CPR from two lay personnel during the five-minute delay before definitive care could be administered by MICP's. This supportive care was clearly life-saving in this patient.

(5) Local hospitals usually must become involved to insure success in such a program. Radio and telemetry usually will be received in the emergency room or CCU for the local hospital where a physician then can give verbal permission to administer medications and fluids. In community hospitals, immediate physician coverage is more common in emergency rooms than in coronary care units. Thus, the emergency room frequently will have to handle communications with paramedics. Physicians who cover emergency rooms frequently have had little training in cardiology and may be reluctant to assume the responsibility of approving the administrations of cardiac medications by paramedics. Hospitals then must utilize teaching resources of local and state agencies mentioned above to provide continual education of MD's providing such coverage.

General Comments

A successful statewide system for pre-hospital coronary care should have the cooperation of all the above groups of agencies to assure success. Certifications and standards must insure safe administration of care but also not be so restrictive that it would be economically impossible for local areas to start programs without federal grants. For example, most areas cannot afford specialized "cardiac vans" but must use the same vehicles and personnel to handle both medical and surgical emergencies. EKG telemetry may be practical in some areas but is not only expensive but technically difficult in rural mountainous areas. At present, certain areas do not have the resources to develop a workable plan. It seems unreasonable to expect all rural areas in this country to have such advanced ambulance systems today without overtaxing present medical resources. Only a small portion of Great Britain, which originated this concept, has such services.

Summary

Treatment of patients in the first hour of a myocardial infarction by ambulance paramedics in other areas lessens mortality significantly. Certified ambulance paramedics in West Virginia recently started successful definitive cardiac care in ambulances. Success of this system requires cooperation of state and local medical societies, the State Health Department, the state and local heart associations, local hospitals and the local government. Structure of any local program must be geared to the local needs and resources.

Congenital Syphilis – A Review

Stephen P. Herman, M. D.

THE history and folklore surrounding the disease we call syphilis is as rich and colorful as the illness's clinical manifestations are protean. No attempt, however, will be made in this review to cover historic syphilology nor the acquired form of the disease. This essay will attempt to touch upon the salient features of congenital syphilis in an effort to alert the physician to the increasing occurrence of this devastating disorder.

The Author

- **Stephen P. Herman, M.D., Department of Pediatrics, West Virginia University School of Medicine, Morgantown; now at the Mayo Graduate School of Medicine, Rochester, Minnesota.**

Epidemiology

It is customary to begin a review of a clinical entity with public health statistics in order to place the illness in an epidemiological prospective. With a venereal disease of any sort, however, such statistics are generally inadequate markers of incidence and prevalence, due to under-reporting and missed diagnosis. However, what figures are available are nevertheless important. There were 106,000 new cases of congenital syphilis of all ages reported nationally in 1947, with a continuous decline by 95 per cent to 6,000 in 1957. In 1964, however, a slow but persistent upward trend was noted, and 15,000 new cases were reported in 1968. But it is estimated that in that year alone perhaps 60,000 cases went unreported.[1]

In 1971, in the United States, 2,052 cases of congenital syphilis in the 0 to 10-year-age group were reported. The figure for the same age group was 1,758 in 1972.[2] The incidence in the State of West Virginia for the past decade is shown in Figure 1. The chart is divided into three categories – the newborn period, infancy to 10 years of age and totals for all age groups each year. It is interesting to note that West Virginia's congenital syphilis rate in fiscal year 1973 was 2.0 per 100,000 population while national statistics reflected only a 0.8 rate per 100,000.[3] The State's rate reflects two and one-half times the national average.

Figure 2 provides a summary of all cases of presumed congenital syphilis seen at the West Virginia University Medical Center since the Hospital opened its doors. There was only one newborn included in this list, primarily for interest, in which no disease was found; the rest are 18 years of age or older, pointing out the important fact that this illness may go unnoticed until well into adulthood.

The Biologic Trinity—Mother, Placenta, Fetus

To understand the pathophysiology of congenital syphilis one must conceptualize in terms of mother, placenta and fetus acting as a unit – all affected in some way by the Treponema pallidum. This spirochete has a spiral morphology of 0.2 millimicrons in width by 5 to 15 millimicrons in length. The spiral coils are one millimicron apart. The organisms are so thin that they can best be seen by dark field illumination. They ordinarily divide by transverse fission. They may form cyst-like structures and possibly have a reproductive cycle. They have never been grown *in vitro*.[4]

A pregnant woman with syphilis often has no primary lesion, or else the chancre may be concealed.[5] As part of general antenatal care, a serologic test for syphilis is done – usually in the first trimester. If the test is negative usually

FIGURE 1

CONGENITAL SYPHILIS IN W. VA. - PAST DECADE

Year	Newborn	Up to 10 yrs. of age	Total
1964	2	2	32
1965	3	0	57
1966	1	1	44
1967	0	1	38
1968	3	0	38
1969	2	1	42
1970	2	0	19
1971	3	0	41
1972	1	0	27
1973	2	1	31

no follow-up tests are performed, although a mother's contracting of the disease late in pregnancy can be devastating to the fetus. Adequate therapy before the fourth month will almost always prevent infection in the newborn. Adequate treatment after 18 weeks will bring about in utero cure if infection has occurred, but this may not prevent bone or joint involvement, neural deafness or interstitial keratitis in the newborn.[6]

In the untreated sero-positive mother, the fetus may still be protected from spirochete invasion through the first trimester.[1] This phenomenon has been thought to be due to a protective mechanism of Langhans' layer of the placental trophoblast, involuting after about four months' gestation. Benerschke[7] disputes this claim, however, noting that other microorganisms can get by the inter-villous spaces of the trophoblast during the first half of pregnancy. He also noted that the Langhans' layer of epithelium does persist throughout gestation but becomes thinner and is not easily seen by staining.

If syphilis has gone undetected throughout gestation there is an 80 to 90 per cent chance of neonatal infection in the first year, a declining rate after the second year and a rare occurrence after four years. Yet, if the fetus is infected, 25 per cent will die as stillbirths or spontaneous abortions, another 25 per cent will die soon after birth and 50 per cent will survive with severe infection.[1]

Overt placentitis is found when antenatal syphilis is diagnosed.[7] There is a great increase in placental weight and in placental:fetal weight ratios in the range of 1:3 or 1:2. The placenta itself is pale - yellowish, bulky and greasy in gross appearance. Histologically, the villi are club-shaped, cellular and sometimes agglutinated. Often a picture of chronic villous inflammation is seen with a proliferative peri- and endo-vasculitis with plasma cell and lymphocytic infilitration. Spirochetes may be seen under dark illumination. Benerschke[7] hypothesizes that in utero fetal death results from luetic endarteritis of the placenta leading to placental infarction, ischemic death and subsequent fetal asphyxia.

In the case of conception resulting in twin births, monozygotic twins usually are both affected or neither is affected. With double-ova twins, one newborn may not be affected.[6]

Pathology

The newborn with syphilis often seems well at birth. Active symptoms at this time are usually

FIGURE 2

SUMMARY OF CASES OF CONGENITAL SYPHILIS AT W. V. U. MEDICAL CENTER

CASE	AGE	SEROLOGY (VDRL)	ILLNESS	PERTINENT COMMENTS
A	40	1:1	Obesity Hypothyroidism	All 8 sibs. treated with Pen. for Cong. Syph.
B	46	?	↓ Hearing Mild Mental Retardation EOM Palsy Ataxia	
C	18	1:32	Atypical Unilateral Clutton's Joint	Mother had + VDRL
*D	newborn	1:2 (cord)	None	STS NR at 6 mo No treatment
E	18	1:64	Mental Retardation Choreoathetosis Mild (L) Hemiparesis Cortical Atrophy Argyll Robertson Pupil	Mother + Serology
F	41	?	↓ Hearing Atrophic Rhinitis Saddle Nose	
G	42	Weakly Reactive	Interstitial Keratitis Anxiety Neurosis	

* Included for interest only, no active disease proven.

of bad prognostic significance. The "classic picture" of the affected newborn is a child with marasmus, a pot belly, withered skin and "old man" facies and the pseudoparalysis of Parrot.[6] The most common physical finding in any series of these infants is hepatosplenomegaly. In Saxoni's[8] series of 18 cases of less than five years of age, 17 had hepatomegaly and 14 had splenomegaly. Only six had any skin manifestations and three had snuffles, the characteristic rhinitis of congenital lues.

Oppenheimer and Hardy[9] at Johns - Hopkins studied autopsy reports of 47 cases from 1940 through 1969. These included 16 live-born and 31 macerated neonates. Of the 16 live-born studied, all had hepatosplenomegaly but only two had snuffles. Thirteen others presented with abdominal distention and 13 were of low birth weight. Interestingly, three cases had no maternal history of syphilis. Other presenting signs in their series included a petechial rash, skin ulcerations, jaundice, bulging fontanelles and thrombocytopenia. Eleven had bone lesions compatible with congenital syphilis.

Neonatal lues can affect virtually every organ system in the body. The histopathology and subsequent clinical presentation is quite variable from case to case. Certain generalizations, however, may be made about microscopic findings.[9] In the various organ systems affected one finds an intense inflammatory reaction in the interstitial stroma and peri - vascular framework rather than in the parenchyma. The area is invaded by mononuclear cells, macrophages, plasma cells and lymphocytes and only rarely by polymorphonuclear leukocytes. With massive inflammation there is often secondary parenchymal damage with compression atrophy and eventual obliteration of the organ's integrity. With decreasing but persistent inflammation,

there is attempted cellular repair with proliferation of fibroblasts and collagen. There may also be extramedullary hematopoiesis not only in the liver and spleen but also in the kidneys, adrenals, lungs, intestines and skeletal connective tissue.

The skin is visibly affected in about 55 per cent of patients within the first six months of life. The lesions are varied and may consist of peeling of the hands and soles and maculopapular or petechial rashes. Vesiculobulbous lesions are uncommon but highly diagnostic. Perioral dermatitis leads to atrophic fissures and the characteristic rhagades. The anogenital region is often involved. There may be hemorrhagic lesions of mucous membranes, and these are infected with the Treponema.[1,6]

The primary luetic lesion of the eye is interstitial keratitis, seen in 30 to 50 per cent of congenital cases. It is more common in females and may initially present unilaterally. The pathophysiology involves vascularization of the cornea with precipitation of cells and pigment on the posterior surface of the cornea. Photophobia is usually present but ulceration is rare. There may be concomitant iritis or iridocyclitis early in the illness and glaucoma later on. The prognosis for the lesion of interstitial keratitis is generally good and topical steroids are of benefit. Corneal transplant may be employed.[1,6]

The ear is often affected by congenital syphilis and only rarely by the acquired disease. This may present as a progressive conductive hearing loss usually occurring in middle or late adulthood. In such a person with no other outward signs of the illness, the serology may be strongly positive, and on biopsy spirochetes may be found in the endochondral bone of the labyrinthine capsule. Kerr et al [10] recommend using ampicillin and prednisone (or ACTH) for this lesion, but treatment successes are varied.

The whitish, sometimes blood-tinged nasal discharge of congenital syphilis is snuffles, and involves obstruction of the mucous membranes. Often presenting with excoriations, it is a persistent rhinitis lasting into the first six months of life in many instances. Later, constant irritation can result in nasal-septal perforation, malar hypoplasia with a flat or dish-shaped facies and the characteristic saddle nose.[1,6]

Congenital syphilis often presents with a characteristic dental lesion. The so-called Hutchinsonian central incisors of the permanent teeth are barrel-shaped teeth. They tend to be short and narrow with a convergence of both lateral margins toward the cutting edge forming a notched pattern. Their color is semi-translucent instead of ivory, and the first molars may also be involved. These notched central incisors may be a pathognomonic sign of neonatal lues.[1,6]

Most of the internal organ systems can be affected by the illness. As examples, the lungs of the newborn may be immature with interstitial inflammation.[9] Rarely in childhood there may be syphilitic valvular heart lesions.[6] The gastrointestinal tract microscopically shows submucosal inflammation or fibrosis. Early mononuclear cell infiltration leads to fibroblastic activity with a greater increase in the submucosal width. There may be focal abscesses throughout the GI tract and secondary Pseudomonas enteritis.[9] Hepatic inflammation leads to hepatomegaly, jaundice, hypoproteinemia and other characteristic signs and symptoms of liver dysfunction.[1]

There is often extensive extramedullary hematopoiesis within the sinusoids and portal triads with concomitant inflammation and collagen fibrosis.[9] There may be peri-acinar fibrosis of the pancreas[1] with a decrease in islet cells and subsequent clinical manifestations of pancreatic failure.[9] Extramedullary hematopoiesis in the splenic sinusoids leads to splenomegaly and the characteristic "onion skin" appearance to the organ.[9] In the kidneys, local inflammation and scarring leads to tubular injury[9] and a postulated immune complex glomerulo-nephritis can lead to severe renal failure or nephrosis.[12] In the male genitalia there may be intense inflammation and interstitial fibrosis of the seminiferous tubules, epididymis, ducts and tunica.[9]

The skeletal system of the newborn is affected in about 75 per cent of cases.[1] There are marked changes in the metaphysis of long bones where normal osteoid tissue is replaced by syphilitic granulation. There is increased density in the zone of provisional calcification and marked periostitis with subperiosteal new bone formation and widening of cortical bone.[6] Bony overgrowth of the skull leads to frontal bossing and maxillomandibular prominence. Osteoclastic activity leads to rarefaction, fragile bony spicules and pathological fractures.[9] The intense pain and tenderness of osteochondritis results in disuse of limbs, the pseudoparalysis of Parrot. Osteitis of the phalanges is known as syphilitic dactylitis. Tibial osteitis results in the characteristic saber-shin deformity and the unusual unilateral thickening of the inner third of the clavicle is known as Higoumenakis' sign.[6]

The joints are often involved, especially the knees. Clutton's joints usually appear in middle and late childhood. This is a syphilitic synovitis without bone or cartilage involvement, usually affecting both knees. There is fever, warmth and pain. The joints appear to respond to steroids but not penicillin or aspirin. In addition to Clutton's joints, there may be a generalized arthritis.[6]

Congenital syphilis frequently affects the central nervous system, with meningitis — often asymptomatic — occurring in 40 to 50 per cent of cases.[6] The CSF often shows a mononuclear pleocytosis with increased protein, decreased glucose and a positive serology.[1] Other CNS manifestations occurring in the neonatal period or later include paralysis, mental retardation, [13] intra-cranial arterial aneurysms[14] and mutism.[15]

The hematopoietic system often reflects a longstanding syphilitic infection with a macrocytic anemia and thrombocytopenia.[8] Additionally, it has been postulated that an autoimmune phenomenon affecting red blood cells leads to paroxysmal cold hemoglobinuria with muscular cramping, headaches, hyperpyrexia and transient hemoglobinuria during exposure to cold.[6]

Diagnosis

Biochemical diagnosis of syphilis is an often confusing area for the clinician because of the plethora of tests and various interpretive approaches. This discussion will of necessity be limited to serologic tests relating to perinatal syphilis.

If a pregnant woman is sero-positive this can never be considered a biological false-positive unless specific Treponema tests are negative. [16] If they are positive, the mother, of course, must be treated. In any infant in whom congenital syphilis is suspected, a serological test of cord blood should be done. However, this test must be recognized for its limitations. A negative serologic test does not exclude syphilis because a recently infected infant may not be sero-positive for some time. Conversely, a positive does not necessarily establish the diagnosis since this may represent passively transferred maternal antibodies.[16] However, cord levels of IgM antibody would be helpful in documenting a fetal infection since this molecule does not cross the placenta.[1] The serological tests for syphilis usually revert to negative — if initially positive — in a noninfected newborn within six weeks to two months of birth, but may remain positive as long as five months of age. Positivity in a seemingly healthy infant greater than two months may mean that the child has an in utero infection which resolved.[16]

According to Rein and Reyne[16] sero-positivity in infants depends on three factors. The first is the serological titer of the mother, to wit: The higher the maternal titer the higher the infant's and the longer the infant remains positive. Secondly, the more sensitive the test the greater the chance of positivity. The third factor is the type of test employed. Passively transferred antibody is more readily detected by complement fixation methods than by flocculation tests. The complement fixating antibody passes through the placenta; the flocculation antibody does not.

Schofield[17] has recently suggested using a newer automated microhemagglutination test with Treponema pallidum as the antigen. This test apparently eliminates biological false-positives and negatives and can then be augmented with other serologic tests for titer determination.

The infant presenting with maternal history, the physical stigmata and serologic evidence of congenital syphilis poses no diagnostic dilemma for the physician. Yet, infants are often born of mothers who were sero-negative in their first trimester and in whom the symptoms of congenital syphilis appear beyond the newborn period.[18] Other problems arise when cord blood serology is positive but the baby appears perfectly healthy. If the mother has been adequately treated during her pregnancy the child should be followed with quantitative serologic tests up to the first four to six months of life. The physician must ultimately make the decision as to whether treatment for the newborn is indicated, based on the historical, clinical and laboratory data that have been gathered.

Treatment

The treatment of choice for congenital syphilis in the neonate is intramuscular therapy with aqueous Procaine Penicillin G, 10,000 units per kilogram per day for 10 days. One injection of Benzathine Penicillin, 50,000 units per kilogram may also be used. The transient febrile Herxheimer reaction occurs in 20 per cent of all cases.[19] Topical steroids are employed for treatment of interstitial keratitis. The newborn should be followed with monthly serologic tests for at least six months and then every three months for a year. Approximately 90 per cent of early well-treated infants will become sero-negative within one year. An older child may never convert to negativity in spite of adequate treatment.

Editorial Conclusions

Congenital syphilis is increasing throughout the United States and in West Virginia. Many

new cases probably remain unreported due to lack of medical suspicion or mis-diagnosis. Current antenatal health programs are inadequately dealing with this problem if only one serologic test is done early in pregnancy and if parents-to-be are not sufficiently educated about the awesome destructive potential of the Treponema pallidum. This review is an attempt to so alert physicians in this era of the "sexual revolution."

Addendum

Shortly after this manuscript was submitted, the first proven case of congenital syphilis was recorded at the West Virginia University Medical Center. The child, a small-for-dates infant, was born to a 20-year-old Gravida II, Para I woman, who was a federal prisoner at the time. The mother had been a heroin user up until the sixth month of pregnancy, and the child exhibited no signs of the narcotic withdrawal syndrome.

The woman had been treated in her last trimester for syphilis, with a 10-day course of penicillin. She was retreated just before delivery, when it was noted that her VDRL and RPR tests were still positive. The cord VDRL of the baby was 1:4. The child appeared normal and was not ill, but x-rays revealed increased areas of radiolucency in the long bones. However, there was no periosteal reaction observed.

The child was treated with penicillin and will be followed.

A list of references may be obtained by writing The Journal.

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Medical Grand Rounds

From the West Virginia University Medical Center

Edited By

Raymond B. Weiss, M. D.
Assistant Professor of Medicine

Polymyalgia Rheumatica and Tophaceous Gout

(Case Presentations)

Polymyalgia Rheumatica

Richard E. Piccirillo, M. D., Medical Resident, West Virginia University Medical Center.

THE patient is a 49-year-old woman who was in good health until approximately April 1974 when she noted the onset of a flu-like syndrome associated with sore throat and general malaise. The acute syndrome abated within two to three days but generalized myalgias persisted. Since that time muscle aching and stiffness had affected the muscles of the shoulder girdle, the upper arms, and proximal thighs. The stiffness was much worse in the morning and would become less marked with increasing exercise. The myalgias were also associated with the feeling of muscle weakness, and she found it most difficult to climb stairs or rise from a chair. She was seen by her physician who prescribed aspirin, but this gave no relief. There was no history of arthritis in the family. She denied any skin problems, and there had been no fever. She denied a history of hot, swollen joints or effusions.

On physical exam she was an afebrile woman in no acute distress. She had limited range of motion of the lumbar spine secondary to pain. There was no range of motion limitation in the upper or lower extremities but there was guarding of the proximal muscles due to the pain.

The sedimentation rate was 61. The LE prep and the anti-nuclear antibody test were both negative. The VDRL was negative. The rheumatoid factor was negative. She had negative chest, lumbosacral spine, and cervical spine x-rays. Electromyogram (EMG) was negative. A muscle biopsy showed no abnormalities and biopsy of the temporal artery was within normal limits. Her CPK was 62, LDH 163, and SGOT of 10. Our clinical impression was that this patient had the syndrome of polymyalgia rheumatica.

Discussion

The criteria for this syndrome have been poorly defined in the past. However, most definitions have included the presence of pain and stiffness in the muscles and periarticular tissues, particularly in relation to the proximal joints of the body, along with evidence of a systemic reaction. Many terms have been used for the syndrome and include some of the following: senile rheumatic gout, secondary fibrositis, periextra-articular rheumatism, periarthrosis humeroscapularis, anarthritic rheumatoid disease and polymyalgia arteritica.

The question arises whether this is a specific disease itself or a non-specific symptom complex which is a manifestation of one or more diseases. There is still confusion concerning the exact relationship between polymyalgia rheumatica and giant cell arteritis. Some consider these a spectrum of disease with a common underlying arteritis, since there are patients with symptoms of polymyalgia rheumatica without demonstrable arteritis at one end of the spectrum and those with arteritis without myalgias at the other end of the spectrum. However, the majority have features of both.

The usual age of the patient is over 50 and most patients with both polymyalgia and cranial arteritis are older. There is a 2:1 female:male ratio in most series reported in the literature. Generally the patients are in good health prior to the onset of their illness. How-

ever, in some reports patients have had a previous period of fatigue. At times there is periarticular pain which is noticed first, such as pain in the biceps tendons or popliteal tendons.

The onset is often rather abrupt with pain and stiffness of the muscles of the proximal portions of the limbs and neck. It is not unusual for the patient to date the onset of pain and stiffness within one or two days. Some have an illness evolving over a longer period, and the symptoms remain relatively mild.

Shoulder girdle and neck muscles are most frequently involved with pain. Hip girdle, lumbar-spinal, and thigh muscles are the next most frequently involved. The muscles can be tender to palpation. The pain is usually symmetric and is usually accentuated by active motion. Morning stiffness similar to that seen in rheumatoid arthritis can be prominent and severe.

Systemic symptoms appear early in the disease and fever, when it does occur, is usually low grade. Anorexia and weight loss have been present in most patients in the series reported. Transient joint swelling can be present as well.

Polymyalgia rheumatica accompanied by symptomatic arthritis often reveals painful temporal arteries which are warm and tender. Arteritis of the large vessels can occur and bruits may be heard over the subclavian, carotid, popliteal or any other artery for that matter. Headache may be present in the patient presenting with polymyalgia rheumatica complicated by cranial arteritis. The headache can be constant or intermittent and when headache is present, the chances of obtaining a positive biopsy of the temporal artery are greater. Headache, however, does not always mean that there is involvement with cranial arteritis.

As for diagnostic studies the increased sedimentation rate is the most striking abnormality. The average is around 70 mm. Westergren method; however, higher ESR's have been noted in patients with associated cranial arteritis. Hypochromic, normocytic anemia can be seen. The white count is usually normal but there may be a slight eosinophilia. Plasma protein abnormalities are common but no consistent or diagnostic pattern is seen. The most common abnormality is a decrease in albumin and an increase in the alpha -1 or alpha -2 globulins as well as fibrinogen.

Rheumatoid factor has been noted in some patients with polymyalgia rheumatica, but LE cell tests have been consistently negative. Serum enzymes (CPK, SGOT, and aldolase) have all been normal and x-rays of joints have shown few changes of any significance. Synovial fluid and synovial biopsy have been done but the series reported have not been large enough to discern any particular pattern. Muscle biopsy is normal and an EMG shows no significant abnormalities. The most important laboratory test to be noted is the elevated erythrocyte sedimentation rate. The other lab data are of limited value except to exclude other diseases such as polymyositis.

As far as temporal artery biopsy is concerned, the percentage of positive biopsies depends on whether the patients are picked according to the signs and symptoms. If the patient is symptomatic, some reports suggest that a 50 per cent positive yield of positive temporal artery biopsies can be obtained. However, if clinical symptoms are excluded and all patients with polymyalgia rheumatica are biopsied, only 8 to 22 per cent have been shown to be involved with temporal arteritis.

Polymyalgia rheumatica is most commonly associated with cranial arteritis. The cranial arteritis can be apparent before, during, or after the onset of the polymyalgia rheumatica. Cranial arteritis will become apparent clinically within one year usually, if it is to become apparent at all. However, some reports have shown patients that have gone two to three years before the first manifestation of arteritis.

There has been much controversy as to the proper treatment of polymyalgia rheumatica. On the basis of clinical criteria, some patients will be classified as polymyalgia until biopsy shows arteritis. Classification, however, according to the temporal artery biopsy is not entirely satisfactory due primarily to the segmental distribution of the arteritis. The histological findings of a normal artery in some patients with overt signs of giant cell arteritis confirms the latter statement. Several authors believe that polymyalgia rheumatica and temporal arteritis should all be treated with steroids for a two-year duration. Biopsy findings at this time can not be used for therapeutic guidelines since serial biopsies have not been done in a large enough series.

Treatment with aspirin, indomethacin, or phenylbutazone have all been shown to obscure the warning symptoms of cranial arteritis when used in patients with polymyalgia rheumatica. Sudden blindness due to ophthalmo - retinal artery occlusion has occurred in patients treated with these drugs. Steroids are the treatment of choice in polymyalgia rheumatica and they often relieve pain of the musculoskeletal symp-

toms and fever within 24 to 48 hours. The ESR returns to normal in time. The initial dose of steroids should be tapered to the lowest level possible that controls the symptoms. There have been no reports of sudden blindness in polymyalgia rheumatica in patients who are being treated with steroids to the point of symptomatic relief and reduction of the ESR to within normal limits. When treating a patient with polymyalgia rheumatica, the most important point to remember is that the majority of the patients recover without any complications after a few months to years and that this disease is self-limited.

Paul D. Saville, M. D., Visiting Rheumatologist, Professor of Medicine, Creighton University School of Medicine, Omaha, Nebraska.

Polymyalgia rheumatica is a syndrome as has been stated. When one saw a patient with this syndrome before 1965 in this country and before about 1952 in Europe we had no diagnostic box to put them in. We examined them, listened to their symptoms, looked for a diagnostic box, and since we couldn't find one, forced them into the nearest box that appeared to almost fit. One of the diagnostic categories the patients are put into in my experience has been rheumatoid arthritis (RA). The differences between this syndrome and rheumatoid arthritis are: (1) when you examine the patient there is no actual sign of arthritis at any joint. The only possible joint involvement is the shoulder and it is not joint pain, but muscle pain. The patient will be found to have a complete range of passive movement of the shoulder. (2) Although the patients have early morning stiffness frequently, the pain, as contrasted to early morning stiffness, is maximal often at night rather than in the day. It interferes with sleep and it occurs in the back. Patients with RA do not have pain in the back and only seldom have pain in the hip joints.

Another incorrect diagnostic category is cervical spondylosis with radicular pain and in my experience cervical spondylosis accounts for only a minor number of syndromes of actual pain in the neck and arms. It should be remembered that if one were to x-ray 100 elderly people, a majority, or at least half, would show evidence of "degenerative changes in the cervical spine." Consequently it is dangerous to ascribe all symptoms in the limbs and neck to cervical spondylosis on the basis of a radiograph.

The last category of some importance that these patients get put into is "psychoneurotic." When you look at them they may be in a wheelchair, unable to dress themselves, feeling ill, depressed and weeping. When you want to know why they are in the wheelchair, they say they can't walk. When you ask why can't they get their jacket off by themselves, they say because they can't move their arms. On examining them you find free range of movement in all their joints. With these findings one should suspect polymyalgia rheumatica and check a blood count and ESR. When you find the sed rate over 50 you begin to feel fairly confident that this may be the diagnosis.

One now has to exclude other diseases. One has to exclude multiple myeloma which is also associated with a high ESR and aching pains so a serum protein electrophoresis and urine test for Bence-Jones protein need to be done. One has to think of cancer. You'd like a chest x-ray as the lung is one of the common sites for malignancy giving rise to these symptoms. Above all else you want to see a clinical response to corticosteroid drugs within four days. If the patient responds dramatically and completely to corticosteroid drugs within four days you can then feel reasonably certain that the diagnosis is correct. If not, it is imperative not to maintain the diagnosis of polymyalgia rheumatica.

As regards to treatment, I give corticosteroids both because they are the most effective treatment and because they are essential for completing the diagnosis. I like to treat the patient for at least two years in order to prevent relapses, and therefore I like to have the patient on either a single dose of steroid a day or a dose every other day. Unfortunately most patients won't respond to alternate day therapy. So I therefore start them on a dose of prednisone 10 mg. q6h and within four days they should respond. Within a week they are healthy and symptom-free, and I then turn to 40 mg. in a single dose. The vast majority of patients maintain their response to this dose. I then decrease the dose steadily for the least possible effective dose which will vary from 5 to 25 mg/day. On this maintenance dose the majority of patients have either no side effects at all or minimal mooning of the face and slight weight gain. I have had a few patients develop compression fractures of the spine during this therapy and it has to be distinguished from further breakthrough of polymyalgic rheumatica with back pain. It is not difficult if you think of it.

Irving Kushner, M. D., Professor of Medicine, Chairman, Division of Rheumatology, West Virginia University Medical Center.

There are two important points to make about polymyalgia rheumatica. (1) In those situations where this syndrome doesn't seem to be secondary to other connective tissue disease or malignancy, it's a self-limited process. If you can carry the patient through the six months to two years' course that it usually runs, the disease abates and she won't need any more medication. (2) There are two major undecided issues in the management of the disease: Should you biopsy everybody's temporal artery, and should everybody get high dose steroids?

Since this disease is so frequent, my own practice has generally been to omit the biopsy in the absence of fever, headaches, visual difficulties, or tenderness of the temporal artery, and treat with high-dose steroids. Since the response to steroids is of diagnostic value, I start with 60 mg. daily, so there won't be any question raised about inadequate dose being blamed for failure to respond. I then gradually decrease the dose over the next six or seven months, following the sedimentation rate to let me know if I'm going too fast. If, after six to 12 months, the patient remains asymptomatic and the sed rate stays down, I'll discontinue therapy and watch both. If neither one gets worse, no further treatment is necessary. Most of the time, however, things don't go this smoothly and tapering must be a slower process.

At the Mayo Clinic where a group headed by Doctor Hunder has been carrying out a number of studies on patients with polymyalgia rheumatica, things are done a little differently. Doctor Hunder reported on several of these studies at the recent Pan American Congress on Rheumatic Diseases in Toronto. What they've been doing is carrying out temporal artery biopsies on *all* of their patients with polymyalgia rheumatica. The ones who have had negative biopsies have been treated with salicylates or low dose prednisone. If, on following them, they fail to respond, they've been looked at again and biopsy repeated. Of 68 patients followed, in five cases rheumatoid arthritis became apparent; in two, repeat biopsy was positive, and in one case carcinoma of the cervix appeared to be the underlying condition. The rest of these patients on aspirin or low dose steroids did well and recovered completely without residual effects. In the patients with positive temporal artery biopsies, they compared 45 mg. a day, either in single or divided doses, with 90 mg. of prednisone every other day. What they found was a generally good response in the patients who received daily therapy, while those who received treatment every other day had neither as good a symptomatic result nor as marked a decrease in the sedimentation rate. The conclusion was that alternate day therapy did not satisfactorily control the symptoms in most patients and could not be recommended.

Figure 1. A view of the patient's fingers showing the far-advanced tophaceous gout with uric acid deposits in all joints. Note the white-colored subcutaneous deposits and the draining sinus (arrows) which are classical for gout. The chalky material can exude from a sinus.

Tophaceous Gout

Donald C. Doll, M. D., Medical Resident, West Virginia University Medical Center.

The patient is a 64-year-old man with a history of chronic gout since the 1950's. He was treated with uricosuric agents and allopurinol, but failed to take his medications regularly. Subsequently, he developed severe crippling gout with tophi formation. He had a history of renal stones and was a chronic alcoholic. Physical exam revealed severe tophaceous deforming arthritis of both hands (Figure 1) and feet. The uric acid was 9.2 mg. per cent on admission and 6. 0 on discharge. X-rays of the hands (Figure 2) and feet were consistent with tophaceous gout. He was begun on allopurinol 500 mg. daily and colchicine 0.5 mg. bid.

Discussion

Monosodium urate crystal deposition disease has been known for centuries. It is now usually well-controlled, and it is rare to see crippling arthritis as in our patient, except in the most severely affected or neglected patients. Gutman[1] pointed out that the tophaceous stage of the problem is a storage disease. The rate of tophaceous deposition in the joints is, in general, a function of the degree and duration of hyperu-

ricemia. There is an increased incidence of tophi if the serum urate value is over 9.0.

Probenecid was first introduced as a uricosuric agent in 1950. It increases uric acid excretion, thus lowering serum urate, by inhibiting the renal tubular reabsorption. It is rapidly and completely absorbed after oral ingestion. In alkaline urine tubular secretion can be demonstrated; in acid urine, probenecid is reabsorbed. Gutman and Yu first documented the mobilization of gouty tophi by uricosuric agents. By using one gram of probenecid daily, they achieved improvement in most cases.

Probenecid is of low toxicity. Some of its side effects (such as gastric distress, precipitation of an acute gouty attack, and uric acid crystalluria) can usually be avoided by using smaller doses, using regular colchicine prophylaxis, or by maintaining liberal fluid intake. Also, one can administer alkali to maintain the urine pH between 6.0 and 6.5.

The drug is not the one of choice in patients with a history of nephrolithiasis. When the glomular filtration rate (GFR) is reduced to 40-50 ml/min., increased doses are required. When the GFR falls to 20-30 ml/min., probenecid is ineffective.

Sulfinpyrazone (Anturan) is a potent uricosuric agent with three distinct properties; antirheumatic, sodium-retaining and uricosuric. It is rapidly absorbed by the GI tract, and is excreted by the renal tubules. It can be substituted for probenecid in those patients who cannot tolerate the latter as it is low in toxicity.

Table 1

Laboratory Diagnosis of Polymyalgia Rheumatica

1. Erythrocyte sedimentation rate is increased.
2. Hypochromic normocytic anemia.
3. White blood count normal globulins.
4. Increased alpha-1 globulins, alpha-2 globulins, and fibrinogen.
5. Muscle enzymes normal (aldolase, CPK, SGOT).
6. Muscle biopsy normal.
7. Electromyography: no abnormalities.
8. Temporal artery biopsy can be positive or negative.

The efficacy of probenecid or sulfinpyrazone in tophaceous gout is well established. Tophi were reduced in size or disappeared in 75 per cent of 360 patients receiving either of these two drugs in one series.

Allopurinol was first synthesized for potential anti-tumor action. Rundles et al first reported the sharp fall in urine and serum uric acid levels with its use. Its toxicity is low. Hypersensitivity reactions, drug fever, mild rashes, epidermal necrolysis, and exfoliative dermatitis have been reported to occur in rare instances. Bone marrow suppression and hepatic dysfunction with a mild SGOT elevation or severe jaundice have also been reported. Xanthinuria with stone for-

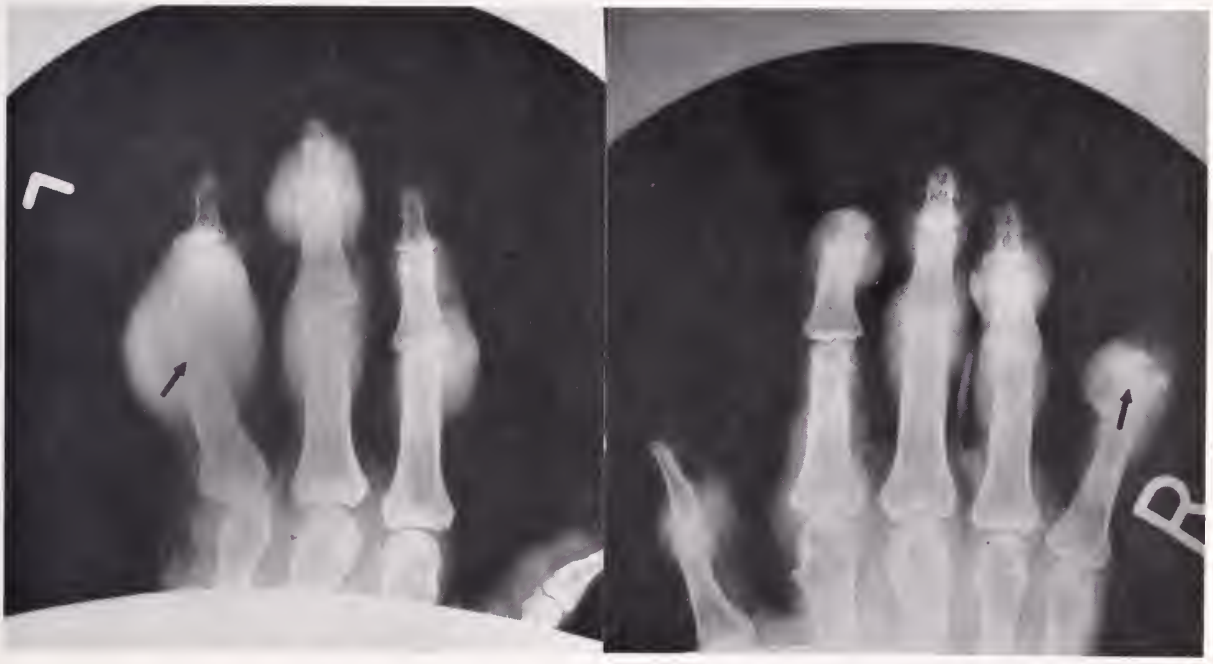

Figure 2. X-rays of the hands showing the soft tissue deposits. Note the marked joint destruction (arrows).

mation is a potential hazard, but it has occurred only in very rare circumstances. Allopurinol is the drug of choice for hyperuricemia in patients with renal stones, renal insufficiency, or high urinary excretion of uric acid.

A combination of probenecid or sulfinpyrazone with allopurinal has been reported to result in more rapid mobilization of tophaceous deposits. However, some large tophi may be quite refractory to treatment. Fortunately, with proper treatment, tophi such as occurred in the patient described, have become and should be a rarity. But with the known failure of our patient to take proper medication in the past, he may not do so now.

Suggested Reading

(1). Fauchald, P., Rygvold, O. and Oystese, B.: Temporal Arteritis and Polymyalgia Rheumatica. Ann. Intern. Med. 77:845-1972.

(2). Yu, T.: Milestones in The Treatment of Gout. Amer. J. Med. 56:676, 1974.

Our Funny Bones

When we ail, we are a bag of bones; and when peace-disturbers dig us up after we have slept for a century, our remains, if we have not been mummified, are our bones. I do not know why bones were made to linger for a thousand years after we have our last need of them; it seems wasteful when other parts of us sensibly refrain from outlasting their usefulness. But that is what gravediggers and archeologists find, just bones. Skin and eyes and nerves and, of course, muscles go quickly, but bones remain. Of course, everything is lifeless then, but that does not matter to bones. They go right on doing their thing, being hard and everlasting.

Skeletons may be on the outside or on the inside, and I vote for the outside, where the hard parts of us can ward off the slings and arrows that go with everyday life. But the heart and lungs are only intermittently covered by thin bony ribs, and the underbelly is entirely unprotected.

Bones moonlight, you might say, for in addition to holding us upright and to furnishing hitchingposts for muscles, they make blood in their spare time.

Bones involve the medical student too, happily or not, for, while he must painfully learn to tell the left clavicle from the right, and to distinguish one vertabra from another, a box of bones assigned to a first-year student will always get him a seat on a crowded bus or train.—*F. C., in The Nebraska Medical Journal.*

What does man have in common with Samson?

Neither man nor the gorilla can synthesize vitamin C. Interestingly, the slow loris, a primate much further down the evolutionary scale, can convert L-1,4-gulonolactone to ascorbic acid in its liver and presumably does not require an exogenous source of ascorbic acid.

Because man can neither synthesize vitamin C nor store most of the water soluble vitamins, these nutrients must be replenished continuously in order to maintain normal tissue levels.

Generally, this is accomplished in his daily diet. But under conditions of illness, stress, in convalescence or following surgery, vitamin stores may be depleted or metabolic demands increased.

In such cases, Surbex-T may be indicated. Surbex-T restores the water-soluble vitamins with each tablet providing 500 mg. of vitamin C plus high potency B-complex.

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Restores what the body cannot effectively store

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When diarrhea wrings the wedding belle...

It's all very well to counsel patience in diarrhea patients. There are times when relief of symptoms can't come too soon.

X-ray studies[1] in 16 normal subjects showed just how promptly the active ingredient in Lomotil does its work.

Lomotil retarded gastrointestinal motility particularly during the first three hours after administration. It continued its moderating action on the bowel for at least three hours more.

Physicians prescribe Lomotil more often than any other drug when the urgency for the control of diarrhea is most distressing.

1. *Demeulenaere, L.: Action du R 1132 sur le transit gastro-intestinal, Acta Gastroent. Belg. 21:674-680 (Sept.-Oct.) 1958.*

Lomotil®

TABLETS/LIQUID

Each tablet and each 5 ml. of liquid contain:
diphenoxylate hydrochloride . . 2.5 mg.
(Warning: May be habit-forming)
atropine sulfate . . . . . 0.025 mg.

Saves the Day

IMPORTANT INFORMATION: *This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or may be evidenced as late as 30 hours after ingestion.* ***LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.***

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria and paralytic ileus.

Dosage and administration: ***Lomotil is contraindicated in children less than 2 years old.*** Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. *Liquid,* 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

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(brand of chlorpheniramine maleate);
50 mg. phenylpropanolamine hydrochloride;
2.5 mg. isopropamide, as the iodide.

ast relief of upper respiratory congestion
nd hypersecretion*
ith convenient b.i.d. dosage.

efore prescribing, see complete prescribing information in SK&F literature or
DR. The following is a brief summary.

Indications
Based on a review of this drug by the National Academy of Sciences — National Research Council and/or other information, FDA has classified the indications as follows:

Possibly effective: For relief of upper respiratory tract congestion and hypersecretion associated with vasomotor rhinitis and allergic rhinitis, and for prolonged relief.

Lacking in substantial evidence of effectiveness: For relief of nasal congestion and hypersecretion associated with the common cold and sinusitis.

Final classification of the less-than-effective indications requires further investigation.

ontraindications: Hypersensitivity to any component; concurrent MAO inhibitor erapy; severe hypertension; bronchial asthma; coronary artery disease; stenosing eptic ulcer; pyloroduodenal or bladder neck obstruction. Children under 6.

arnings: Caution patients about activities requiring alertness (e.g., operating hicles or machinery). Warn patients of possible additive effects with alcohol and ther CNS depressants.

sage in Pregnancy: In pregnancy, nursing mothers and women who might bear ildren, weigh potential benefits against hazards. Inhibition of lactation may occur.

ffect on PBI Determination and I^{131} Uptake: Isopropamide iodide may alter PBI st results and will suppress I^{131} uptake. Substitute thyroid tests unaffected by xogenous iodides.

recautions: Use cautiously in persons with cardiovascular disease, glaucoma, rostatic hypertrophy, hyperthyroidism.

dverse Reactions: Drowsiness, excessive dryness of nose, throat or mouth; ervousness; or insomnia. Also, nausea, vomiting, epigastric distress, diarrhea, rash, izziness, weakness, chest tightness, angina pain, abdominal pain, irritability, alpitation, headache, incoordination, tremor, dysuria, difficulty in urination, hrombocytopenia, leukopenia, convulsions, hypertension, hypotension, anorexia, onstipation, visual disturbances, iodine toxicity (acne, parotitis).

upplied: Bottles of 50 capsules; in Single Unit Packages of 100 (intended for nstitutional use only).

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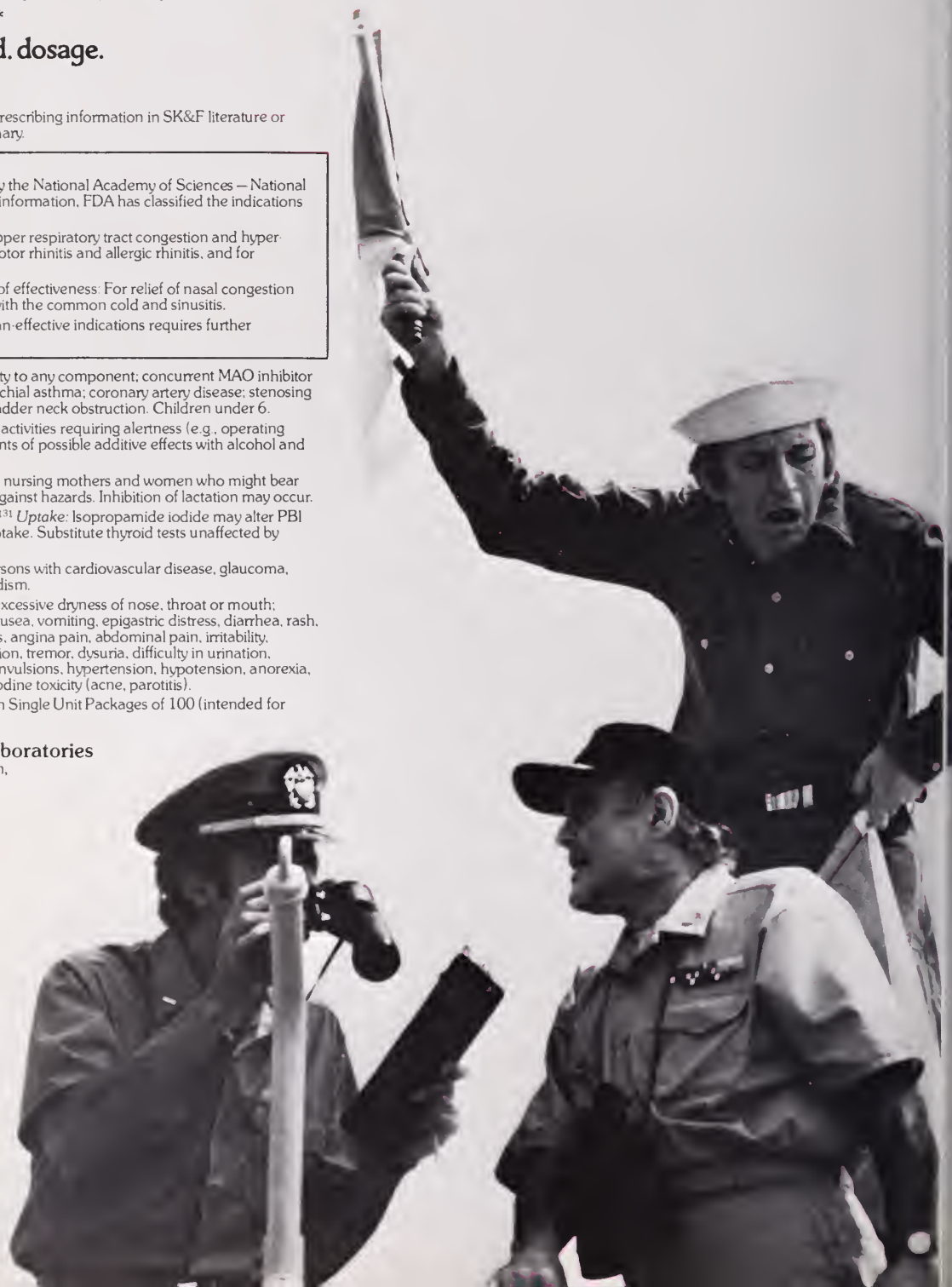

A Continuing Medical Education Event!

Such sponsors and participants as the West Virginia State Medical Association; West Virginia Diabetes Association; West Virginia Heart Association; West Virginia Lung Association and its Kanawha County Council; West Virginia University School of Medicine and its Alumni Association; West Virginia Chapter, American Society of Internal Medicine; West Virginia Medical Institute, Inc.; Kanawha Medical Society and Woman's Auxiliary to the Kanawha Medical Society; West Virginia Division, American Cancer Society.

are pleased to announce

"The Eighth Mid-Winter Clinical Conference"

Daniel Boone Hotel

Washington and Capitol Streets
Charleston, West Virginia

2 P.M. and 8 P.M. Friday, January 24
9:30 A.M. and 2 P.M. Saturday, January 25
9:30 A.M. Sunday, January 26

THE PROGRAM again will offer a wide-ranging clinical and educational experience for the practicing physician. FRIDAY AFTERNOON, January 24, session on heart diseases; FRIDAY EVENING, presentations will include PSRO's and a session open to the public on the "problems of adolescents." A medically oriented program on problems of adolescents will be held SATURDAY MORNING, January 25 with these other scheduled subject areas to follow: SATURDAY AFTERNOON, cerebral vascular diseases and diabetes; SUNDAY MORNING, January 26, pulmonary disease in adolescents, cancer and "How to Avoid Malpractice."

THE FACULTY will include outstanding specialists in their fields from various educational and other settings, both outside and from within West Virginia.

THE PROGRAM CO-CHAIRMEN again are Ralph H. Nestmann, M. D., and Joseph T. Skaggs, M. D., both of Charleston. Also on the Program Committee are William O. McMillan, Jr., M. D., of Charleston, and C. Carl Tully, M. D., of South Charleston.

THE REGISTRATION FEE of $15 for the entire conference will be charged all registrants except nurses, medical students, interns and residents. Advance registration is requested, and please make checks payable to "WEST VIRGINIA STATE MEDICAL ASSOCIATION."

ACCREDITATION: Attendance will be acceptable for Category 1 credit toward the Physician's Recognition Award of the American Medical Association; and the program also is expected to carry prescribed credit by the American Academy of Family Physicians.

OVERNIGHT ACCOMMODATIONS: Physicians should communicate directly with the reservation manager of the hotel or motor inn of their choice, with the conference headquarters hotel setting aside rooms for registrants.

FOR ADVANCE REGISTRATION, please complete the form below and mail to: WEST VIRGINIA STATE MEDICAL ASSOCIATION, P. O. BOX 1031, CHARLESTON, W. VA. 25324.

- -

Please register me for the Eighth Mid-Winter Clinical Conference in Charleston, W. Va., January 24-26, 1975. My $15 registration fee is (is not) enclosed.

I will attend sessions at 2 P. M. Friday, January 24 ..... 8 P. M. Friday ..... 9:30 A. M. Saturday, January 25 ..... 2 P. M. Saturday ..... 9:30 A. M. Sunday, January 26 ..... All sessions ..... .

Name (please print) _____ *Specialty* _____

Address _____ *City* _____

A message from . . .

The President

FIRE! FIRE! FIRE!

In the few weeks I have served the West Virginia State Medical Association in this office, the opportunity to visit component medical societies in West Virginia, to see new places and to meet new friends, has been great! For me, such visits may well be the heart of both opportunity and responsibility.

Less satisfying professionally, but no less important, are the trips Maxine and I take to the medical society meetings of adjacent or nearby states. Already, we have been to Ohio, Kentucky, Indiana and Pennsylvania. And, by the time this journal is received, we will have been to the District of Columbia and Virginia meetings as well!

In our peripheral States, *professional liability* has replaced PSRO on the front burner. This is of "crisis" magnitude. Today, some of our colleagues in other states are without, and cannot obtain, professional liability insurance *at any price!* Emergency rooms and operating theaters in some hospitals are closing because of the problem. Increased incidents and larger awards have made professional liability insurance untenable, or at best, have resulted in gross premium increases.

Those of us in West Virginia are still fortunate enough to be able to buy a thicker sheet of asbestos to shield us from the fire. But how long can we allow the fire to rage unchecked? Though "asbestos" is needed urgently, we must simultaneously reduce the fire. *Legislation* of several forms appears to be the only logical long-term solution. Otherwise, personal concerns will overshadow patient concerns. Otherwise, where is our future?

Bill Gilmore

William E. Gilmore, M. D., *President*

THE WEST VIRGINIA MEDICAL JOURNAL

Official Organ of the West Virginia State Medical Association

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Editor
GEORGE F. EVANS, M. D.
122 South Sixth St.
Clarksburg, W. Va.

Managing Editor and
Business Manager
MR. WILLIAM H. LIVELY
Box 1031
Charleston, W. Va. 25324

Associate Editors:
VERNON E. DUCKWALL, M. D.
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EDITORIALS

THE VALUE OF CASE REPORTS

Although this editorial is addressed principally to young members of the medical profession, it is hoped that the older and more experienced practitioners will also find it of interest. It has always been the feeling of the author of this editorial that young physicians, who are really well educated people, should be encouraged to submit articles to medical journals, especially to their state medical journal. I am convinced that there are young practitioners of medicine in the State who like to write and who are capable of presenting acceptable and interesting manuscripts to reputable medical journals.

If the practitioner, be he young or old, feels that he (or she) does not have sufficient material on hand to write an article, it should be borne in mind that a well-written case report is always in order. Surely there are physicians who from time to time in their practice see interesting and perhaps unusual cases. These worthwhile cases by all means should be reported, for some of them are of interest and importance to many other physicians, and perhaps even more so than a long article. The length of the report depends somewhat on the number of cases reported. Obviously if only one case is described, the article should not be long. If references are necessary, they should be carefully chosen.

The author should review his manuscript with care and make revisions if needed. There are indeed but few persons who can sit down and write a paper, the first draft of which needs no revision. Many careful and experienced writers revise their manuscript a number of times. A good plan is to lay the manuscript aside for a few days and then peruse it; in many instances certain portions will be found which need further revision.

If the author feels he needs guidance in writing up a case report, he should seek it; in fact, it is always a good idea to ask some competent person to review the manuscript before submitting it for publication. The author of this essay, who has had considerable experience in medical writing, never hesitates to ask some experienced person or persons to review his manuscript. By so doing he often receives valuable suggestions. Indeed we are all prone to make mistakes and all learn by experience. An author should strive for clarity and accuracy. The latter is of fundamental importance, for in this world of confused thinking accuracy is a quality to be highly prized.

RICHARD W. CORBITT, M.D. (1914-1974)

For more than a quarter of a century Dr. Richard W. Corbitt has been a distinguished member of the medical profession in Parkersburg. A skilled surgeon and brilliant diagnostician, the position Doctor Corbitt occupied in the area of specialized medicine was one of eminence and high station.

Aside from his duties as a healer of the ill, Doctor Corbitt was vitally interested in the welfare of his community. He was a man of great warmth and friendliness whose positive approach to affability and extension of courtesy was widely recognized and deeply appreciated.

Doctor Corbitt brought to Parkersburg from the Mayo Clinic a conspicious acquaintance with the facts, truths and principles of medical care. He was acknowledged as one of the top men in his field, both as a surgeon and practicing physician.

Doctor Corbitt's death removes from this community a man whose profound influence, and capacity for perception was widely recognized. In this hour of bereavement, this newspaper extends to the family of Doctor Corbitt our deepest and most sincere sympathy.

—The Parkersburg News

Has any other one man done so much for the safety of athletes? This question popped into my mind Tuesday when I was informed of the death of Dr. Richard Corbitt. It was my privilege to work with Dr. Dick when he was fighting for greater safety measures for football players.

His accomplishments in the field of medicine have been listed elsewhere along with a background of his career. But little has been written of Doc's contributions to safety, his love for athletics and his devotion to Parkersburg High School.

It was Doctor Corbitt who led the fight to have high school football start August 1 in West Virginia. He insisted that the two weeks of early practice be reserved for conditioning so that youngsters would be physically ready for contact.

It was one of Doctor Corbitt's suggestions that halftime be extended three minues so that the players would have time to warm up before the kickoff.

It was Doctor Corbitt who arranged for and took charge of the pre-season physical examinations for Parkersburg high schools and junior highs. Many, many times I have visited PHS and South at 8 A.M. on a Thursday morning in late July and found Doc Corbitt in his white working clothes leading a team of volunteer physicians in giving complete physicals to aspiring young football players.

And it was Dr. Richard Corbitt who started the student trainer program at Parkersburg High School. If ever a program was vitally needed it was this one. And it's spread to other schools in this city and others because, as Dr. Dick often said, a student trainer who knows what he is doing is just as important as any player.

Doctor Corbitt's work with athletic injuries and his untiring efforts to find the cause and adopt corrective measures endeared him to every youngster who ever aspired to be anything in the Wonderful World of Sports.

Some of the glitter has gone out of the local sports world, which has lost one of its true champions. Dr. Richard Corbitt was a friend to many, and a true sportsman who believed in athletics but who felt that not enough emphasis was placed on injuries, their cause and effect.

Sympathy is extended to Mrs. Corbitt, to the children and to the future generation of athletes who won't have Dr. Dick looking after their wellbeing.

He'll be missed!

—Jim Snyder, in The Parkersburg News

CARBON-MONOXIDE ABSORPTION IN CIGARETTE AND CIGAR SMOKERS

Of late years smoking cigarettes has received a great deal of comment not only in medical journals but in the lay press as well. Cigarette advertising is no longer allowed on television and cigarette packages contain a warning that smoking is injurious to the health. Be all that as it may, the sale of cigarettes continues to rise which presumably means that many men and women still indulge in cigarette smoking. There is no doubt but that it is a health hazard.

It is generally conceded that habitual cigar and pipe smokers have only slightly greater mortality rates than non-smokers, whereas habitual cigarette smokers have a significantly higher mortality. This difference is thought to be due to the fact that cigar and pipe smokers do not inhale. On this account it is often suggested that individuals who are heavy cigarette smokers change to smoking cigars.

A relevantly recent article in *The Lancet*[1] deals with this problem. Seven men who were heavy cigarette smokers gave up cigarettes and changed to smoking cigars. Carboxyremoglobin (CoHb) levels had been determined during the time the men were smoking cigarettes and again after they had changed to cigar smoking. The CoHb levels when smoking cigars were similar to those when they were smoking cigarettes. This plainly indicated that these seven men continued to inhale after changing to cigars. It was concluded that cigarette smokers who change to cigar smoking may not lower the risk to their health.

The authors of the article point out that cigar smokers who inhale are likely to risk their health for a number of reasons. It has been shown that CoHb may be an important factor in the development of atherosclerosis. The urinary nicotine excretions in those who inhale cigars is similar to those who inhale cigarettes. As a result of the catecholamines secretion thereby induced the mobilization of free fatty acids is also considerably increased. It also has been shown by animal tests that the condensate of pipe and cigar smoke is more likely to produce cancer when applied to the skin than is condensed cigarette smoke. It would seem that it is possible that cigar smokers who inhale may actually run a greater risk to their health than those who continue to smoke cigarettes. Finally, the authors of the article emphasize that on present evidence no encouragement should be given to heavy cigarette smokers to change their habit and smoke cigars.

1. Cowie, J. et al., The Lancet (1:1033 (May 12) 1973.

GIFTS TO MEDICAL SCHOOLS

The physicians of West Virginia are indeed to be congratulated for the generous funds they gave to the School of Medicine of West Virginia University during the calendar year of 1973. A recent communication from the American Medical Association and Research Foundation lists the grants to approved medical schools during the year 1973.

Two types of grants are listed. Those earmarked by donors for the school and grants to schools from undesignated funds. The list contained 118 approved medical schools in the United States. West Virginia University School of Medicine fared well for it received $12,045.19 of earmarked funds. Twenty-nine schools received more than West Virginia University School of Medicine — but in a number of instances the amount was slight.

The three medical schools which received the largest donations were: Northwestern University School of Medicine, $39,999.38; University of Illinois College of Medical Foundation, $38,-748. 57; and the University of Alabama School of Medicine, $35,822.90. The average for the earmarked funds for the 118 approved medical schools in the United States was $8,808.04. Some of the old and prestigious schools did not fare as well as might be expected: Harvard School of Medicine, $9,443.76; Johns Hopkins University School of Medicine, $8,892.36; and the University of Pennsylvania School of Medicine, $14,-122.56. This is somewhat difficult to explain.

The Foundation granted a sum of $1,921.85 from undesignated funds to all approved schools (except five undeveloped schools). The total amount of money from both funds, that is, the earmarked and undesignated funds amounted to $1,039,349.77. Since the tuition medical students pay is far less than the expense of their training, gifts are most welcome especially those which are unrestricted.

The author of this essay feels that every alumnus should pay some money each year to the medical school from which he was graduated. There are some alumni who do not agree with certain educational policies of their school or object to some administrative policies and, as a consequence, stop their annual contributions. This is wrong, because policies of medical schools change as do administrators.

If an alumnus believes firmly that certain changes should be made, his criticisms should be presented to the alumni association. If they seem valid, the members of the alumni association could vote on them and submit their opinion to the proper authorities of the school.

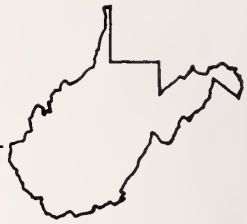
In many instances redress probably would be obtained. In sum, the important thing is that alumni contribute annually to the school from which they received their M.D. degree.

AMA Training Program Announced

The American Medical Association will conduct a series of 10 seminars in 1975 to train physicians to serve as medical directors in skilled nursing facilities.

The objective will be to provide a joint training experience for physicians, administrators and nurses to enhance the ability of the physician to serve as a medical director.

GENERAL NEWS



WVU, U. of Cincinnati Physicians To Be On Mid-Winter Program

Dr. G. Robert Nugent, West Virginia University School of Medicine, and Dr. Harvey C. Knowles, Jr., University of Cincinnati College of Medicine, have accepted invitations to speak at the Eighth Mid - Winter Clinical Conference next January 24-26 in Charleston at the Daniel Boone Hotel. Doctor Nugent, Professor and Chairman of the Division of Neurosurgery at WVU, will speak Saturday afternoon, January 25, on "The Surgical Management of Cerebral Vascular Disease." Doctor Knowles is Professor of Medicine at the University of Cincinnati and a Past President of the American Diabetes Association. He will follow Doctor Nugent at the Saturday afternoon session with the topic of "Vascular Changes in Diabetes Mellitus." As previously announced, Dr. Arthur L. Poffenbarger, Charleston neurologist, will be the first speaker for the Saturday afternoon session, beginning at 2 P. M. His subject will be "The Diagnosis and Medical Management of Cerebral Vascular Disease."

H. C. Knowles, Jr. M.D.

The Conference will conclude at noon on Sunday, with scientific sessions scheduled for Friday afternoon, Saturday morning and afternoon, and Sunday morning.

On Friday evening, there will be a public session under the general topic of "Problems of Adolescents," with the speakers also to address a medically-oriented session for physicians on the same subject Saturday morning. These speakers, as previously announced, will be Dr. U. G. Turner, III, University of Virginia School of Medicine, whose topic will be "Human Sexuality and Youth, A Timely Challenge;" Dr. Ralph S. Smith, Jr., Charleston psychiatrist, who will discuss teenage suicides, and a third speaker, yet to be confirmed, whose subject will be teenage drugs and alcoholism.

Concurrent with the public program Friday evening will be a session for physicians on PSRO entitled "PSRO Revisited One Year Later."

The West Virginia University School of Medicine Alumni Association will meet Friday afternoon preceding the evening sessions.

The other speakers and their topics previously announced are:

"Mobile Coronary Care Unit" — Richard S. Crampton, M. D., Department of Internal Medicine, University of Virginia Medical Center; "Cardiac Emergencies in Children" — Nancy Wanderman, M. D., Assistant Professor of Pediatrics, Pediatric Cardiology, Charleston Division, WVU Medical Center (Friday afternoon);

"PSRO Revisited One Year Later" — James C. Respess, M. D., Department of Internal Medicine, University of Virginia School of Medicine; and William C. Felch, M.D., Rye, New York (Friday evening physician's session);

"Pulmonary Disease in Adolescents" — C. E. Buckley, III, M. D., Department of Medicine, Duke University Medical Center; and "How to Avoid Malpractice Suits"—Stanley E. Preiser, Charleston attorney (Sunday morning).

Kanawha Medical Society Offers Social Event

Physicians, wives and others attending the Mid-Winter Clinical Conference are invited to the annual dinner dance of the Kanawha Medical Society which will be held Saturday, January 25, in the Daniel Boone Hotel ballroom beginning at 7 P.M. The affair will include cocktails, dinner and dancing. Dress will be formal.

The cost will be $12.50 per person. Advance registration is requested. Registrations and advance payment, if desired, should be sent to the Kanawha Medical Society, 405 Atlas Building, Charleston 25301. Payment also may be made at the door. Checks should be made payable to the Kanawha Medical Society.

All registrations should be in by January 21.

To be announced are a speaker on cancer and an additional speaker on heart diseases.

Physicians, wives and guests will be invited to attend the annual dinner dance of the Kanawha Medical Society Saturday evening at the Daniel Boone.

Attendance at the Conference will be acceptable for Category 1 credit toward the Physician's Recognition Award of the American Medical Association; the Conference also is expected to carry prescribed credit by the American Academy of Family Physicians. A registration fee of $15 for the entire conference will be charged all registrants except nurses, medical students, interns and residents.

The program Co-Chairmen again are Drs. Ralph H. Nestmann and Joseph T. Skaggs, both of Charleston. Also on the Program Committee are Drs. William O. McMillian, Jr. of Charleston and C. Carl Tully of South Charleston.

The annual Mid-Winter Clinical Conference is sponsored by the State Medical Association in conjunction with some of its component medical groups, and volunteer health agencies.

Additional details will be provided in later issues of *The Journal* as the program takes final shape.

Fall Meeting of the Council In Charleston on Oct. 6

The Fall Meeting of the Council was held at the Heart-O-Town Motor Inn in Charleston on Sunday, October 6, 1974, with the Chairman, Dr. A. Thomas McCoy of Charleston, presiding.

At the outset, Doctor McCoy requested those present to stand for a moment of silent prayer in memory of the late Dr. Richard W. Corbitt of Parkersburg, who served as President of the West Virginia State Medical Association during 1968-69.

New Members of the Council

Doctor McCoy introduced the following new members of the Council who were elected during the meeting at The Grenbrier in August:

Drs. David F. Bell, Jr., of Bluefield; L. Walter Fix of Martinsburg; Ray M. Kessel of Logan; and Lyle D. Vincent of Parkersburg. Another new member, Dr. Walter E. Klingensmith of Beckley, was unable to attend due to a conflict in meetings.

At the request of Dr. C. A. Hoffman, Chairman of the Insurance Committee, Doctor McCoy introduced the following members of the Insurance Committee who were invited specifically to attend the meeting: Drs. John T. Chambers of Charleston; Fay Perry Greene, Jr., of Parkersburg; and Buford W. McNeer of Hinton. Also introduced was Mr. Guy D. Beaumont, Jr., of Columbus, AMA Field Representative.

Professional Liability Insurance Program

Doctor McCoy pointed out that the primary reason for calling a meeting of the Council at such an early date was due to the fact that Doctor Hoffman and members of the Insurance Committee were of the opinion that members of the Council and the physicians they represent throughout the State should be made aware of the present professional liability insurance situation in West Virginia.

Doctor Hoffman introduced Mr. F. M. (Mike) Taylor of Charleston, Coordinator for the Association's Professional Liability Insurance Program in West Virginia, who, in turn, introduced the principal spokesman, Mr. Robert Grimes of Hartford, Connecticut, Superintendent of Underwriting for the Aetna Life & Casualty Company.

Also present to answer questions was Mr. Joseph W. Boutaugh of Wheeling, Manager of Underwriting for Aetna Life & Casualty Company in West Virginia.

There ensued a discussion of approximately two hours during which time Mr. Grimes and Mr. Taylor presented facts and answered questions concerning the Association's program as well as the general trend of malpractice coverage for physicians throughout the county.

It was pointed out during the session that it would be necessary to increase the premium effective January 1, 1975, for physicians enrolled in the program from 23 per cent to 148 per cent depending on the member's specialty. The majority of the members will be faced with a premium increase of approximately 45 per cent.

Action of Council

Following the presentation, members of the Council unanimously accepted the report and directed that a copy be mailed to the entire membership as soon as possible over the signature of Doctor Hoffman.

Doctor McCoy suggested to the representatives of Aetna that if at all possible future reports on the Association's group liability program be prepared prior to the annual meetings of the Association so that the report could be presented to those present at meetings of the House of Delegates.

(Subsequently, a report on the Professional Liability Insurance Program was mailed to the entire membership on October 16).

Publication Committee Member Reelected

Dr. George F. Evans of Clarksburg was unanimously reelected a member of the Publication Committee for the term ending on December 31, 1981. Doctor Evans has served as Editor of *The Journal* since 1962 and in that position is in charge of reviewing the scientific and editorial material submitted for publication in *The Journal*.

Election of Honorary Member

Dr. Harold H. Kuhn of Big Pine Key, Florida, who practiced his specialty of orthopedic surgery in Charleston for a number of years, was elected to honorary membership in the State Medical Association, effective January 1, 1975.

Report on West Virginia Medical Institute

Mr. Charles R. Lewis, the West Virginia Medical Institute's Executive Director, told the Council that (1) the Institute has submitted to Federal authorities a draft of a statewide Professional Standards Review Organization (PSRO) plan for West Virginia under terms of its planning contract with the U. S. Department of Health, Education and Welfare; and (2) the Institute put 135 cases into its professional review mechansim in the first eight weeks of operation under its medical consultant contract with the Blue Cross and Blue Shield plans for Southern West Virginia.

He also reported that Institute membership had climbed to 838 West Virginia doctors of medicine and osteopathy.

Catastrophic Medical Expense Plan

The Council voted unanimously to approve enrollment of staff members of the State Medical Association in a Catastrophic Medical Expense Plan offered by Blue Cross-Blue Shield of Southern West Virginia, Inc. It was pointed out that the total annual increase in the hospital insurance program for staff members would be minimal and would serve as an added fringe benefit.

Need for Physicians in Certain Areas

It was reported that the Preston Council Health Council, Inc., Tri-District Community Health Service and the Mountaintop Health Services, Inc., had requested the Council to certify the need of assignment of physicians by the National Health Service Corps in those areas of the State.

The Cocunil voted to endorse the above mentioned projects after being assured that the officers of component medical societies in those areas also had certified the need.

Report of Medical Economics Committee

Dr. Carl J. Roncaglione, Chairman of the Medical Economics Committee, presented a brief report in which he stated that a majority of the activities of the Committee are still in the development stage following adoption of certain resolutions and policies during the annual meeting in August. He said a more detailed report would be submitted to Council at a later date.

He pointed out, however, that one area did need attention. He said that many of the third-party agencies believed that physicians have an obligation over and above that of taxpayers to perform services for clients of these agencies for less than the usual and customary charges.

Doctor Roncaglione also recommended that an effort be made by the Association for members of its committees to have an input into the policies promulgated by all third-party agencies.

Health Manpower Legislation

Doctor Andrews reviewed various bills in Congress pertaining to health manpower and explained briefly how the bills could affect medical education and the practice of medicine throughout the country.

He said most of the major health legislation in Congress this year would not be acted upon finally until after November 11 when Congress reconvenes following a recess for the general election.

Circulation of Council Minutes

It was reported that the Council of the Kanawha Medical Society had requested that there be more general circulation of the minutes of meetings of the Council of the State Medical Association through distribution of same to the secretaries of component medical societies.

This matter was discussed at length and referred to the Executive Committee for study and report back at the next meeting of the Council.

Proposed Budget

It was reported that the Cabell County Medical Society, at a meeting held in Huntington on September 17, 1974, had passed a resolution that a more complete and detailed financial statement of the Association be submitted in writing semi-annually by the Treasurer to the Council for inclusion in the minutes of the Council meetings and that the annual audit by a disinterested reputable accounting firm continue to be performed yearly and published in *The West Virginia Medical Journal.*

During the discussion, it was pointed out that the Council should be responsible for an accurate accounting of the business practices of the Association at all times.

The Council voted unanimously that a proposed budget be submitted to the Council for review and approval at the first meeting during the fiscal year — usually held during the month of January.

The meeting was attended by Dr. A. Thomas McCoy of Charleston, Chairman; Dr. William E. Gilmore of Parkersburg, President; Dr. Jack Leckie of Huntington, President Elect; Dr. John J. Mahood of Bluefield, Vice President; Dr. Kenneth G. MacDonald of Charleston, Treasurer; Drs. Robert R. Weiler of Wheeling; Charles E. Andrews of Morgantown; Ray M. Kessel of Logan; L. Walter Fix of Martinsburg; Robert D. Hess of Bridgeport; Louis W. Groves, Jr., of Richwood; Lyle D. Vincent of Parkersburg; J. L. Mangus of Charleston; David F. Bell, Jr., of Bluefield; Mr. William H. Lively of Charleston, Executive Secretary; Mr. Custer B. Holliday of Charleston, Executive Assistant; Mr. Charles R. Lewis of Charleston, Special Projects Director.

Also attending the meeting were Drs. Frank J. Holroyd of Princeton and Richard E. Flood of Weirton, AMA Delegates; Dr. George R. Callender, Jr., of Charleston, AMA Alternate; Dr. C. A. Hoffman of Huntington; Dr. James S. Klumpp of Huntington, Parliamentarian; Dr. Carl J. Roncaglione of Charleston; Dr. John T. Chambers of Charleston; Dr. Buford W. McNeer of Hinton; Dr. Fay Perry Greene, Jr., of Parkersburg; Mr. Robert Grimes of Hartford, Connecticut; Mr. Joseph W. Boutaugh of Wheeling; Mr. F. M. Taylor of Charleston; and Mr. Guy D. Beaumont, Jr., of Columbus, AMA Field Representative.

Dr. Richard W. Corbitt Dies at Age 59

Dr. Richard W. Corbitt of Parkersburg, a Past President of the West Virginia State Medical Association and active in many civic and community organizations, died in Parkersburg on October 1.

Richard W. Corbitt, M.D.

Doctor Corbitt was 59 years old at the time of his death and had practiced his specialty of urology in Parkersburg for the past 28 years.

A native of Waverly, Wood County, son of the late Dr. Robert Wylie and Nora Triplett Corbitt, he was graduated from Parkersburg High School in 1932 and from West Virginia University in 1936. He received his M. D. degree in 1939 from the University of Maryland School of Medicine and served an internship and residency at Mercy Hospital in Baltimore. He also served a Fellowship in Urology at the Mayo Foundation and was First Assistant in Urology at the Mayo Clinic in Rochester, Minnesota.

Doctor Corbitt earned two battle stars while serving with the Medical Corps of the United States Navy in the South Pacific, 1944-46.

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Doctor Corbitt located his practice at Parkersburg in 1946 and immediately became active in organized medicine on the county, state and national levels. He served a term as President of the Parkersburg Academy of Medicine and was elected to the Council of the State Medical Association in 1961. He was named Vice President in 1966, President Elect in 1967 and was installed as President in 1968. He served as Chairman of the Association's Council after his term as President.

He was a Diplomate of the American Board of Urology, a Fellow of the American College of Surgeons and a member of the American Medical Association and the American Urological Association.

He was a Past President of the Greater Parkersburg Chamber of Commerce and had served as Coroner of Wood County for 27 years until a few months ago. He also had served as Chief of Staff at St. Joseph's and Camden-Clark Memorial hospitals.

Doctor Corbitt had excelled as a wrestler and trackman in high school and college and his interest in sports never waned. He served for a number of years as team physician at Parkersburg High School and his close affiliation with the Coaches Association in the State earned him the distinction of being named "Honorary Coach" by the members of that organization.

He served for a number of years as a member of the State Medical Association's Committee on the Medical Aspects of Sports and in 1970 was named a member of the Committee on Sports of the American Medical Association. He was serving as Chairman of that Committee at the time of his death.

Doctor Corbitt also served as Chairman of the West Virginia Commission on Postmortem Examinations from its establishment in 1963 and was a member of the Review Board for Secondary Schools Activities Commission of West Virginia.

Doctor Corbitt is survived by his wife, Margaret Maguire Corbitt; five daughters, Charlotte and Margaret of Parkersburg; Mary Louise, a student at West Virginia University; Mrs. Marcia Wilson of Charleston; and Mrs. Sheila Grimm of Glastonburg, Connecticut; two sons, Terrence of Marietta, Ohio; and Richard, Jr., also a student at West Virginia University; and four grandchildren.

He was preceded in death by a son, Robert Emmett.

New AAP President Installed

Dr. John C. MacQueen, Professor of Pediatrics at the University of Iowa, was installed as the 45th President of the American Academy of Pediatrics, during the Academy's recent annual business meeting in San Francisco.

The 16,000 member Academy is the Pan-American association of physicians certified in the care of infants, children and adolescents.

Doctor MacQueen is also the Director of the University of Iowa's Oakdale Hospital; Iowa State Services for Crippled Children; and Ambulatory Care Services, Department of Pediatrics, University of Iowa.

Doctor MacQueen has served the AAP in several previous capacities. He was Chairman of the Academy's Iowa Chapter for many years. He has been Chairman of the AAP's District VI and a member of the Academy's Council on Pediatric Practice during that same period.

State Physicians To Participate In SMA Atlanta Convention

West Virginians will have prominent roles in scientific and business sessions of the Southern Medical Association's 68th Annual Scientific Meeting, November 17-20, in Atlanta at the Marriott Motor Hotel.

Jack Leckie, M. D.

D. Franklin Milam, M. D.

Dr. Albert C. Esposito of Huntington, a Past President of the SMA, will continue as a member of the Board of Trustees until 1977.

Drs. Jack Leckie and William L. Neal of Huntington are Chairman and Secretary, respectively, of the SMA's Section on Family Practice, which will meet on Tuesday, November 19. Doctor Leckie is President Elect of the State Medical Association.

Dr. D. Franklin Milam of Morgantown is Vice Chairman of the Section on Urology. Doctor Milam, Professor and Chairman of the Department of Urology at the West Virginia University School of Medicine, will present a scientific paper during the meeting of the Section on Monday, November 18. The title of his paper will be "Lesions of the External Genitalia."

Dr. Hilton C. Rocha, a member of the staff of Hopemont State Hospital, will present a scientific exhibit on "Emotional Disorders in the Aged — Practical Aspects of Recognition and Management."

Dr. M. Bruce Martin of Huntington is a member of the SMA's Council.

Oliver H. Loyd, WVU School of Medicine, will be one of 39 junior Medical Student Representatives to the convention.

More than 6,000 physicians and paramedical personnel are expected to attend the convention, which will feature scientific sessions of 21 medical specialties. Section work is augmented by general sessions, joint sessions, special symposia, scientific closed circuit television programs featuring surgical procedures and demonstration live from a local hospital, live teaching demonstrations at the site of the meeting, postgraduate courses, learning center with experts in chosen fields, meeting of conjoint societies, and scientific and technical exhibits.

The Section on Orthopedic Surgery of the West Virginia State Medical Association met during the Association's 107th Annual Meeting, August 21-24, at The Greenbrier in White Sulphur Springs. Seated, from left, are Drs. Athey R. Lutz of Parkersburg; Carl J. Roncaglione and George R. Callender, Jr., of Charleston; and Thomas F. Scott and Robert W. Lowe, both of Huntington; standing, from left, Drs. Nicholas D. Zambos, Beckley; Lawrance S. Miller, Morgantown; Robert R. Weiler, Wheeling; J. Hugh Wiley, Morgantown; John P. Griffith, Jr., Wheeling; and Arthur A. Abplanalp, Charleston.

Portland Site For AMA Clinical Convention, Nov. 30 - Dec. 4

Postgraduate education for physicians will be the focus of the 28th Clinical Convention of the American Medical Association, November 30 - December 4, at Portland, Oregon.

Frank J. Holroyd, M. D.

Richard E. Flood, M. D.

Special sessions on specific medical problems and a variety of basic training courses to assist physicians in updating and refining their skills will be offered, along with special programs on medical aspects of sports, medical writing, public speaking and basic guidelines in formation of a small health group for rural areas.

The scientific programs will be held in Portland's Memorial Coliseum.

The AMA's policy-making body, the House of Delegates, will meet simultaneously at the Portland Hilton Hotel. The first session of the House will begin at 2 P. M. on Sunday, December 1. West Virginia Delegates to the House are Drs. Richard E. Flood of Weirton and Frank J. Holroyd of Princeton, with Drs. Harry S. Weeks, Jr., of Wheeling and George R. Callender, Jr., of Charleston as Alternates.

In line with the usual schedule, Reference Committees of the AMA House will meet on Monday, December 2, to consider and hold hearings on the resolutions, reports and other items before them. The House will reconvene on Tuesday morning, December 3, for two additional days of sessions.

More than 100 scientific exhibits will be an added educational feature of the convention, as will a program of medical motion pictures, a Fireside Forum program and round-table discussion luncheons. Six special sessions on specific medical problems will be presented during the convention.

Total attendance of more than 5,000 is anticipated. The AMA last met in Portland in 1963.

The complete program for the Convention was published in the October 14 issue of *The Journal of the American Medical Association.*

Dr. Leo H. T. Bernstein Elected State Heart Assn. President

Dr. Leo H. T. Bernstein of Martinsburg was elected President of the West Virginia Affiliate of the American Heart Association during its Annual Meeting and Scientific Sessions September 27 and 28 at Oglebay Park in Wheeling. He succeeds Dr. Michael F. Wilson of Morgantown.

Leo H. T. Bernstein, M. D.

Also elected were Dr. George H. Khoury of Morgantown, President Elect; and Dr. Howard B. Sauder of Wheeling, Vice President. Mrs. Josephine Fultz, R.N., of Clarksburg, was appointed Vice Chairman of the Board of Directors. The current Chairman of the Board, Kenneth Weber, Ph.D., of Morgantown, began his second year of a two-year term.

Doctor Bernstein has served as President-Elect, a member of the State Board and Chairman of the State Nominating and Awards Committee. A specialist in internal medicine, Doctor Bernstein is the immediate Past President of the West Virginia Chapter of the American Society of Internal Medicine. A native of New York City, he was graduated from Rutgers University and earned a Ph.D. degree from Johns Hopkins University. He received his M. D. degree in 1949 from the University of Utah.

Doctor Bernstein interned at Salt Lake County General Hospital. He was a Fellow in cardiology at George Washington University Hospital and served a residency in internal medicine at the Martinsburg Veterans Administration Center.

He is a Diplomate of the American Board of Internal Medicine and a member of the American Society of Microbiologists, the American Association for Advancement of Science, and the Association of Military Surgeons of the United States.

Doctor Khoury is a member of the State Board of Directors and has served as Chairman of the Monongalia County Unit in 1973-74. He is a pediatric cardiologist at the West Virginia University School of Medicine.

Change of Address

Members of the West Virginia State Medical Association are requested to notify the headquarters offices promptly concerning any change in address. Notices should be mailed to Box 1031, Charleston, West Virginia 25324.

Standing and Special Committees Appointed by Doctor Gilmore

The following standing and special committees have been named by Dr. William E. Gilmore of Parkersburg, President of the West Virginia State Medical Association, to function during his one-year term of office:

Aging

Eldon B. Tucker, Morgantown, Chairman; Myer Bogarad, Weirton; and Richard Hamilton, St. Marys.

Cancer

Alvin L. Watne, Morgantown, Chairman; John J. Battaglino, Jr., Wheeling; Walter B. Bice, Jr., and F. Lloyd Blair, Parkersburg; Harry F. Cooper, Beckley; L. Walter Fix, Martinsburg; David B. Gray, Charleston; Ray A. Harron, Bridgeport; Catalino B. Mendoza, Jr., Clarksburg; Hu C. Myers, Philippi; Jess S. Renedo, Wheeling; Richard G. Starr, Beckley; Charles W. Thacker, Parkersburg; John W. Trenton, Kingwood; James H. Walker, Charleston; and Chauncey B. Wright, Huntington.

Constitution and By-Laws

Harry S. Weeks, Jr., Wheeling, Chairman; George R. Callender, Jr., Charleston; Richard E. Flood, Weirton; S. William Goff, Parkersburg; Carl B. Hall, Charleston; J. C. Huffman, Buckhannon; James S. Klumpp, Huntington; Athey R. Lutz, Parkersburg; Richard V. Lynch, Jr., Morgantown; and L. J. Pace, Princeton.

Insurance

C. A. Hoffman, Huntington, Chairman; James A. Barnes, Beckley; John T. Chambers, Charleston; R. U. Drinkard, Wheeling; A. C. Esposito, Huntington; L. Walter Fix, Martinsburg; F. Perry Greene, Jr., Parkersburg; Upshur Higginbotham, Bluefield; Logan W. Hovis, Vienna; Kenneth G. MacDonald, Charleston; Buford W. McNeer, Hinton; J. C. Pickett, Morgantown; and C. Vincent Townsend, Martinsburg.

Interprofessional Relations

George R. Callender, Jr., Charleston, Chairman.

Sub-Committees

Medico-Legal: A. J. Villani, Welch, Chairman; John C. Bryce, Parkersburg; George V. Hamrick and Paul H. Revercomb, Charleston.

Medicine and Religion: Tracy N. Spencer, Jr., South Charleston; Dwight P. Cruikshank, Parkersburg; and V. L. Dyer, Petersburg.

Medicine and Pharmacy: R. C. Cowan, Jr., Parkersburg, Chairman; John L. Fullmer, Morgantown; and L. Dale Simmons, Clarksburg.

Medical-Dental Liaison: George L. Armbrecht, Wheeling, Chairman; Alberto G. Capinpin, Charleston; and James A. Thompson, Clarksburg.

Nurses Liaison: Richard E. Flood, Weirton, Chairman; Billie M. Atkinson, Parkersburg; Jean P. Cavender, Charleston; John J. Mahood, Bluefield; and L. J. Pace, Princeton.

Legislative

Frank J. Holroyd, Princeton, Chairman; W. P. Bittinger, Oak Hill; J. E. Blaydes, Jr., Bluefield; A. Paul Brooks, Parkersburg; John T. Chambers, Charleston; George A. Curry, Morgantown; Del Roy R. Davis, Kingwood; Roy A. Edwards, Jr., and A. C. Esposito, Huntington; George Gevas, Parkersburg; Paul E. Gordon, Clarksburg; Louis W. Groves, Jr., Richwood; N. B. Groves, Martinsburg; Carl B. Hall, John M. Hartman, John W. Hash and John A. B. Holt, Charleston; J. C. Huffman, Buckhannon; M. V. Kalaycioglu, Shinnston; Jack Leckie, Huntington; Charles L. Leonard, Elkins; Milton J. Lilly, Jr., Charleston; Paul L. McCuskey, Parkersburg; Charles W. Merritt, Beckley; Thomas G. Reed, Charleston; Joseph D. Romino, Fairmont; Carl J. Roncaglione, William B. Rossman and Page H. Seekford, Charleston; Robert G. Shirey, Lewisburg; Jack J. Stark, Belpre, Ohio; I. Ewen Taylor, Huntington; A. J. Villani, Welch; David E. Wallace, Madison; Stephen D. Ward, Wheeling; Henry F. Warden, Jr., Bluefield; J. Hugh Wiley, Morgantown; and David E. Yoho, Glen Dale.

Maternal and Perinatal Fetal Welfare

Frederick H. Dobbs, Charleston, Chairman; Walter A. Bonney, Jr., Morgantown; Clarence H. Boso and Thomas J. Conaty, Huntington; Robert D. Crooks, Parkersburg; Larry D. Curnutte, Charleston; T. Keith Edwards, Bluefield; Thomas G. Folsom, Huntington; N. W. Fugo, Morgantown; George Gevas, Parkersburg; Robert Greco, Morgantown; George L. Grubb, Charleston; C. S. Harrison, Clarksburg; Edwin J. Humphrey, III, Huntington; W. Gene Klingberg, Morgantown; A. Robert Marks, Clarksburg; Rose H. McClanahan, Charleston; Charles W. Merritt, Beckley; Thomas G. Potterfield, Charleston; Robert P. Pulliam, Beckley; Meryleen B. Smith, Peterstown; A. J. Villani, Welch; Gates J. Wayburn, Huntington; and Patrick C. Williams, Jr., Charleston.

Medical Aspects of Sports

K. Douglas Bowers, Jr., Morgantown, Chairman; R. L. Chamberlain, Buckhannon; Robert A. Crawford, Jr., and Henry R. Glass, Jr., Charleston; Joe N. Jarrett, Oak Hill; James S. Kessel, Ripley; Jack C. Morgan, Fairmont; George Naymick, Weirton; W. H. Rardin, Beckley; Carl J. Roncaglione, Charleston; George W. Rose, Clarksburg; Michael A. Santer, Jr., Parkersburg; J. G. Vasquez, Grantsville; Herbert E. Warden, Morgantown; and Moseley H. Winkler, Charleston.

Medical Economics

Carl J. Roncaglione, Charleston, Chairman; and W. Alva Deardorff, Charleston, Vice Chairman.

Sub-Committees

Federal Medical Activities: J. L. Mangus, Charleston, Chairman; George R. Callender, Jr., Charleston; Daniel Hale, Princeton; Richard V. Lynch, Jr., Morgantown; James T. Spencer and James H. Walker, Charleston.

State Workmen's Compensation: Lawrance S. Miller, Morgantown, Chairman; Marshall J. Carper, Jacques Charbonniez and W. Alva Deardorff, Charleston; Daniel W. Dickinson, Wheeling; A. C. Esposito, Huntington; Robert L. Ghiz, Charleston; Charles E. Haislip, Fairmont; Thomas J. Holbrook, Huntington; Ralph J. Holloway, South Charleston; James T. Hughes, Ripley; M. V. Kalaycioglu, Shinnston; Theodore P. Mantz and William C. Morgan, Jr., Charleston; S. P. Nayak, Charlton Heights; James E. Powers, Princeton; Clifford A. Stevenson, Beckley; James H. Walker, Charleston; and Robert R. Weiler, Wheeling.

Blue Cross-Blue Shield Third Party: Milton J. Lilly, Jr., Charleston, Chairman; Charles E. Andrews, Morgantown; Robert W. Bess, Jr., Piedmont; Donald R. Chadwick, Beckley; C. A. Hoffman, Huntington; George W. Hogshead, Nitro; Logan W. Hovis, Vienna; Ray M. Kessel, Logan; Milton E. Nugent, Wheeling; and J. D. H. Wilson, Clarksburg.

Public Welfare — Joint Conference Committee: Thomas P. Long, Man, Chairman; George R. Callender, Jr., Charleston; C. Richard Daniel, Beckley; Clemente Diaz, Richwood; Richard E. Flood, Weirton; N. B. Groves, Martinsburg; John M. Hartman, Charleston; W. Gene Klingberg, Morgantown; Seigle W. Parks, Charleston; and J. D. H. Wilson, Clarksburg.

Medical Education and Hospitals

Pat A. Tuckwiller, Charleston, Chairman; William O. McMillan, Jr., Charleston, and Richard V. Lynch, Jr., Morgantown, Vice Chairmen; Charles E. Andrews, Morgantown; M. David Avington, Parkersburg; Leo H. T. Bernstein, Martinsburg; Rowland H. Burns, Huntington; William H. Carter and John T. Chambers, Charleston; Creel S. Cornwell, Clarksburg; Del Roy R. Davis, Kingwood; C. Richard Daniel, Beckley; Thomas O. Dotson, White Sulphur Springs; William J. Echols, Huntington; T. Keith Edwards, Bluefield; Albert C. Esposito, Huntington; Alfred D. Ghaphery, Wheeling; Robert D. Hess, Bridgeport; Upshur Higginbotham, Bluefield; Winfield C. John, Huntington; George M. Kellas, Wheeling; Jack Leckie, Huntington; Mary Lou L. Lewis, Charleston; Eugene McClung, Lewisburg; Michael D. McNeer, Wheeling; David Z. Morgan, Morgantown; Benjamin L. Plybon, Ronceverte; Herbert H. Pomerance, Charleston; Joseph B. Reed, Buckhannon; Thomas G. Reed, Charleston; Joe Wesley Rhudy, Morgantown; Howard B. Sauder, Wheeling; Harold Selinger and Edwin M. Shepherd, Charleston; Philip M. Sprinkle, Morgantown; Richard G. Starr, Beckley; Hartwell G. Thompson, Charleston; C. Vincent Townsend, Martinsburg; John W. Traubert, Morgantown; John C. Turner, Fairmont; and J. Hugh Wiley, Morgantown.

Medical Scholarships

Martha Jane Coyner, Harrisville, Chairman; Marshall J. Carper, Charleston; Robert D. Hess, Bridgeport; Thomas J. Holbrook, Huntington; Russel Kessel, Charleston; John Mark Moore, Wheeling; A. L. Poffenbarger, Charleston; and Clark K. Sleeth, Morgantown.

Medical Emergencies and Civil Defense

John A. B. Holt, Charleston, Chairman; Harold D. Almond, Buckhannon; Dominic A. Brancazio, Weirton; Harry F. Coffman, Keyser; Salvador Diaz, Huntington; Ernest G. Guy, Philippi; Charles H. Hiles, Wheeling; Donald R. Lantz, Parkersburg; John J. Mahood, Bluefield; Joseph T. Mallamo, Fairmont; John B. Markey, Charleston; James G. Ralston, Clarksburg; William S. Sadler, Barboursville; Lyle D. Vincent, Parkersburg; John W. Whitlock, Beckley; and E. Andrew Zepp, Martinsburg.

Mental Health

Roy A. Edwards, Jr., Huntington, Chairman; Mildred Mitchell - Bateman, Charleston; Randall Connolly, Vienna; Humberto Escandon, Parkersburg; Thomas S. Knapp, Charleston; S. Elizabeth McFetridge, Shepherdstown; L. J. Pace, Princeton; William B. Rossman, Charleston; Robert E. Sams, Parkersburg; A. L. Wanner and Stephen D. Ward, Wheeling; Charles C. Weise, Charleston; and A. C. Woofter, Parkersburg.

Military Medical Affairs

Russel Kessel, Charleston, Chairman; Bert Bradford, Jr., Charleston; Robert D. Hess, Bridgeport; and Logan W. Hovis, Vienna.

Program

Philip M. Sprinkle, Morgantown, Chairman; R. J. Bailey, Parkersburg; Fernando G. Giustini, Wheeling; Robert D. Hess, Bridgeport; Jack Leckie, Huntington; and Joseph T. Skaggs, Charleston.

Public Service

Albert C. Esposito, Huntington, Chairman; John M. Bobbitt, Huntington; George A. Curry, Morgantown; C. R. Davisson, Weston; Leonard M. Eckmann, South Charleston; G. Thomas Evans, Fairmont; Louis W. Groves, Jr., Richwood; N. B. Groves, Martinsburg; Carl E. Johnson, Morgantown; E. Lee Jones, Wheeling; C. A. Logue, Morgantown; George E. McCarty, Parkersburg; Charles W. Merritt, Beckley; L. J. Pace, Princeton; Joseph B. Reed, Buckhannon; Page H. Seekford, Charleston; Jack J. Stark, Belpre, Ohio; Stephen D. Ward, Wheeling; and A. J. Weaver, Clarksburg.

Resolutions

Richard E. Flood, Weirton, Chairman; George R. Callender, Jr., and A. Thomas McCoy, Charleston; Worthy W. McKinney, Beckley; L. J. Pace, Princeton; and Harry S. Weeks, Jr., Wheeling.

Rehabilitation

Buford W. McNeer, Hinton, Chairman; Jean P. Cavender, Charleston; James A. Gardner, Beckley; James A. Heckman, Huntington; Thomas M. Howes, Morgantown; Francis H. Hughes, Parkersburg; Ralph H. Nestmann, Charleston; J. C. Pickett, Morgantown; Jack Pushkin, Charleston; M. D. Reiter, Wheeling; L. Dale Simmons, Clarksburg; Robert R. Weiler, Wheeling; J. Hugh Wiley, Morgantown; Roy James Yates, Beckley; and Cenon D. Zerrudo, Parkersburg.

Rural Health

Martha Jane Coyner, Harrisville, Chairman; Harold D. Almond, Buckhannon; J. C. Arnett, Rowlesburg; Ralph H. Boone, Sistersville; B. S. Brake, Clarksburg; Robert W. Coplin, Elizabeth; Del Roy R. Davis, Kingwood; N. H. Dyer, Charleston; Vernon L. Dyer, Petersburg; Earl L. Fisher, Gassaway; Robert R. Frye, Mannington; O. M. Harper, Clendenin; Mehmet V. Kalaycioglu, Shinnston; Charles T. Lively, Weston; Ralph McGraw, Follansbee; Joseph B. Reed, Buckhannon; Charles J. Sites, Franklin; and Charles E. Staats, Charleston.

Tuberculosis

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Project HOPE Opens New Program in Nigeria

Project HOPE opened a new medical teaching-training program in Nigeria in September, Dr. William B. Walsh, founder and President of the international teaching organization, reported recently.

The program will be centered at the University of Ife, about 150 miles northeast of the capital of Lagos, and HOPE personnel will be working with the University's Faculty of Health Sciences. The faculty at Ife was founded to assist the western state of Nigeria to improve its health services not only by the education of doctors but also by the training of the complete health team.

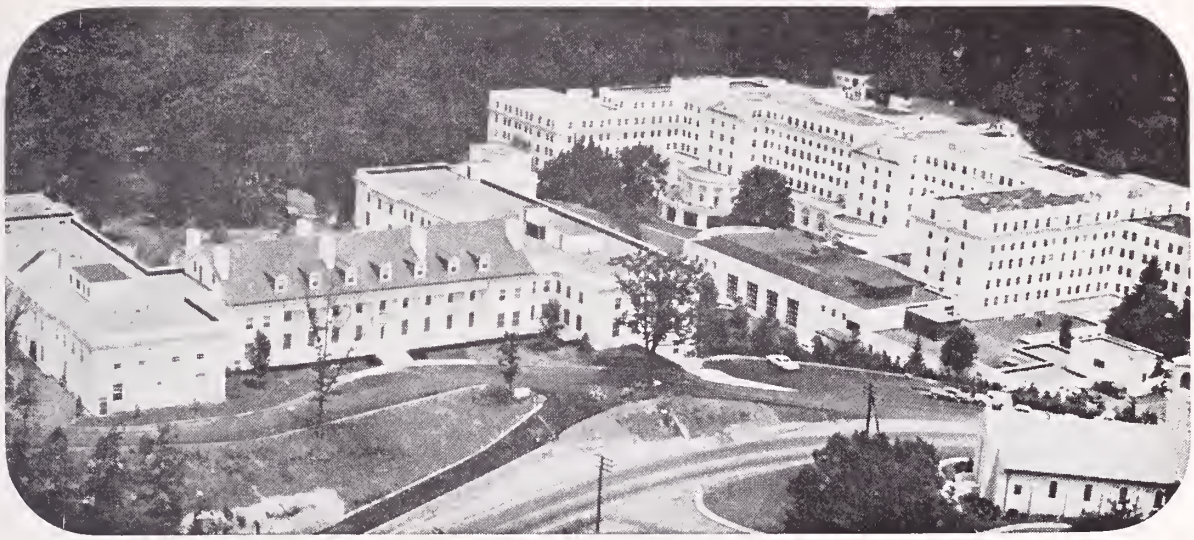
As it does for each of its programs, a HOPE survey team will travel to Nigeria to confer with those involved in the program and to plan a program specifically to meet the needs of that country.

HOPE is a private, nonprofit organization supported primarily by contributions from individuals and organizations, including business, organized labor and industry.

108th ANNUAL MEETING

of the

West Virginia State Medical Association



The Greenbrier

AUGUST 20-23, 1975

PLAN NOW TO ATTEND

Dr. Carl B. Hall Elected!

Dr. Carl B. Hall of Charleston was named President Elect of The American Academy of Family Physicians during the organization's 1974 annual meeting in Los Angeles in mid-October.

Word of his election reached us as this issue of *The Journal* was placed on the press but more complete information will be published in the December issue of *The Journal.*

SMA Cancer Information Center Has Successful First Year

The Southern Medical Association Cancer Information Center has been refunded for a two-year period by the National Cancer Institute upon completing its first and highly successful year in operation. The announcement was made recently by Dr. George Carroll, President of the Southern Medical Association.

The Dial Access System, a breakthrough in cancer education, was launched at SMA's 67th Annual Scientific Meeting at San Antonio in November 1973. It is co-sponsored by the University of Texas M. D. Anderson Hospital and Tumor Institute.

A telephone communication and consultation service for cancer education and control, the Dial Access System provides physicians, dentists, nurses, health-science students and other health practitioners with immediate access to the latest diagnostic and therapeutic information regarding human cancer through a simple toll-free telephone call.

The system includes five WATS interswitchable lines to tape cartridge players carrying a tape library of 265 different discussions. This concise information is authored by members of SMA with expertise in the study and management of various types of human cancer, and the staff of the Universty of Texas M. D. Anderson Hospital and Tumor Institute. The tapes are continually updated when new information becomes available.

Catalogue Distributed To 60,000

A complete catalogue of the taped conversations was distributed earlier this year to 60,000 physicians by the Southern Medical Association.

"We are highly gratified over the acceptance of this important program," Doctor Carroll said. "The fact that it has been refunded for two years means that we can develop additional areas of coverage and expand and update many phases of the system."

Doctor Carroll said comments about the program were highly laudatory. In general, physicians were reassured by the Dial Access System's ability to resolve professional differences of opinion, to provide an immediate prognosis when necessary, to provide directional assistance for further research and to save valuable time.

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled in the coming months.

1974

Nov. 1-2—Clinical Chemistry, Pathology Sem., Morgantown.
Nov. 1-3—Med. Soc. of D. C., White Sul. Springs.
Nov. 3-4—Am. Coll. of Chest Physicians, New Orleans.
Nov. 3-6—Med. Soc. Va., Williamsburg.
Nov. 6-9—Am. Soc. Cytology, N. Y. City.
Nov. 9-14—Am. Soc. Maxillofacial Surgeons, Houston.
Nov. 14-16—W. Va. Chap., ACS, Morgantown.
Nov. 16-20—Amer. Acad. for Cerebral Palsy, Denver.
Nov. 17-20—Southern Med. Assn., Atlanta.
Nov. 18-22—Am. Heart Assn., Dallas.
Nov. 21-24—Clinical Immunology and Allergy, Ft. Lauderdale, Fla.
Nov. 30-Dec. 4—AMA Clinical, Portland.

Dec. 1-6—Radiological Society of N. America, Chicago.
Dec. 6—Am. Coll. Chemosurgery, Chicago.
Dec. 7-10—Am. Soc. Hematology, Atlanta.
Dec. 7-12—Am. Acad. Dermatology, Chicago.
Dec. 9-12—Southern Surgical Assn., Boca Raton, Fla.
Dec. 10-11—Am. Medical Soc. on Alcoholism, San Francisco.
Dec. 11-15—Am. Psychoanalytic Assn., N. Y. City.
Dec. 16-17—New Drug Sem. (Natl. Cancer Institute), Washington, D. C.

1975

Jan. 9-11—Symp. on Late Consequences of Successful Cancer Therapy, Orlando, Fla.
Jan. 24-26—8th Annual Mid-Winter Clinical Conf., Charleston.
Jan. 29-Feb. 1—Southern Society for Pediatric Research, New Orleans.
Jan. 31-Feb. 2—Southern Radiological Conf., Point Clear, Ala.

Feb. 10-13—Am. College Cardiology, Houston.
Feb. 13-15—Southern Neurosurgical Soc., San Antonio.
Feb. 15-19—Amer. Acad. of Allergy, San Diego.
Feb. 17-20—Southeastern Surgical Congress, Atlanta.
Feb. 21-28—Am. Soc. of Clinical Pathologists and College of Am. Pathologists, Las Vegas.

Mar. 1-6—Am. Acad. of Orthopaedic Surgeons, San Francisco.
Mar. 20-21—Natl. Conf. of Rural Health, Roanoke, Va.
Mar. 30—April 4—Am. Coll. of Radiology, Portland.

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WVU Medical Center
–News–

• Compiled from material furnished by Mrs. Mary Ellin Wylie, Director, Medical Center News and Information Services, Morgantown, W. Va.

Dr. Paul D. Saville, a native of England, has been named Chairman of the Division of Rheumatology in the West Virginia University School of Medicine's Department of Medicine.

Born and educated in London, Doctor Saville came to the United States in 1958 as a Cass Ledyard Fellow in the New York Hospital's Department of Pediatrics.

He comes to WVU from Creighton University in Omaha, Nebraska, where he was Professor of Medicine and Director of the Metabolic Research Unit. His academic experience also includes five years on the faculty of Cornell University Medical College.

He holds membership in a number of professional societies including the Orthopedic Research Society, the Royal College of Physicians of London, the American Association for Advancement of Science, and the American College of Physicians.

His primary fields of interest are bone metabolism and orthopedic medicine, and he is the author or co-author of 40 publications in several research areas.

Detect Lung Cancer By Blood Test?

A research program so vital and extensive that it requires the services of 13 scientists and clinicians and an expenditure of more than $100,000 a year is now under way at the West Virginia University Medical Center.

Its ultimate goal is to increase the life chances of victims of lung cancer through the earliest diagnosis possible by identifying cell change before tumors become apparent.

If the researchers find the answers they are seeking, it may be possible to detect the presence of lung cancer by a blood test. A long range potentiality could be the development of a vaccine which would increase resistance to cancer, attack existing cancer cells or prevent tumor recurrence.

The blood test for cancer diagnosis is the immediate goal, however.

"We have the sensitive instruments and techniques to accomplish this end," said Robert Veltri, WVU Associate Professor of Otolaryngology and Microbiology and Chief Research Investigator.

But before a clinical pathologist can utilize the markers of lung cancer in the blood stream diagnostically, the research scientist must find and isolate such markers. To do so, he must go directly to the cancer cell itself.

Diagnosis of lung cancer is now made by x-ray, a cytologic test which examines sputum for the presence of abnormal cells, and bronchoscopy.

But all of these methods presuppose the presence of a tumor manifesting itself as a shadow on an x-ray or sloughing off abnormal cells, some of which may be already invading the blood stream to establish malignant colonies in other parts of the body.

Earlier signs of cell abnormality, even before a tumor is clinically detectable, would give the best chance for cure.

The markers of lung cancer which the WVU scientists are seeking are termed tumor-associated antigens.

An antigen is a protein substance usually found on the cell surface. A tumor-associated antigen, according to Doctor Veltri, would be such a substance not previously expressed by the normal cell—a molecule not ordinarily produced.

If the body's immune system recognizes these tumor-associated antigens as expressions of abnormal or foreign tissue, antibodies against such antigens will be produced. The presence and identification of such antibodies is also part of the WVU research.

Antigens have been found and isolated for several types of cancer, and implications both for diagnosis and treatment have been promising in research carried out at a number of centers throughout the United States.

Like the program at WVU, most of this research is financed and directed by the National Cancer Institute.

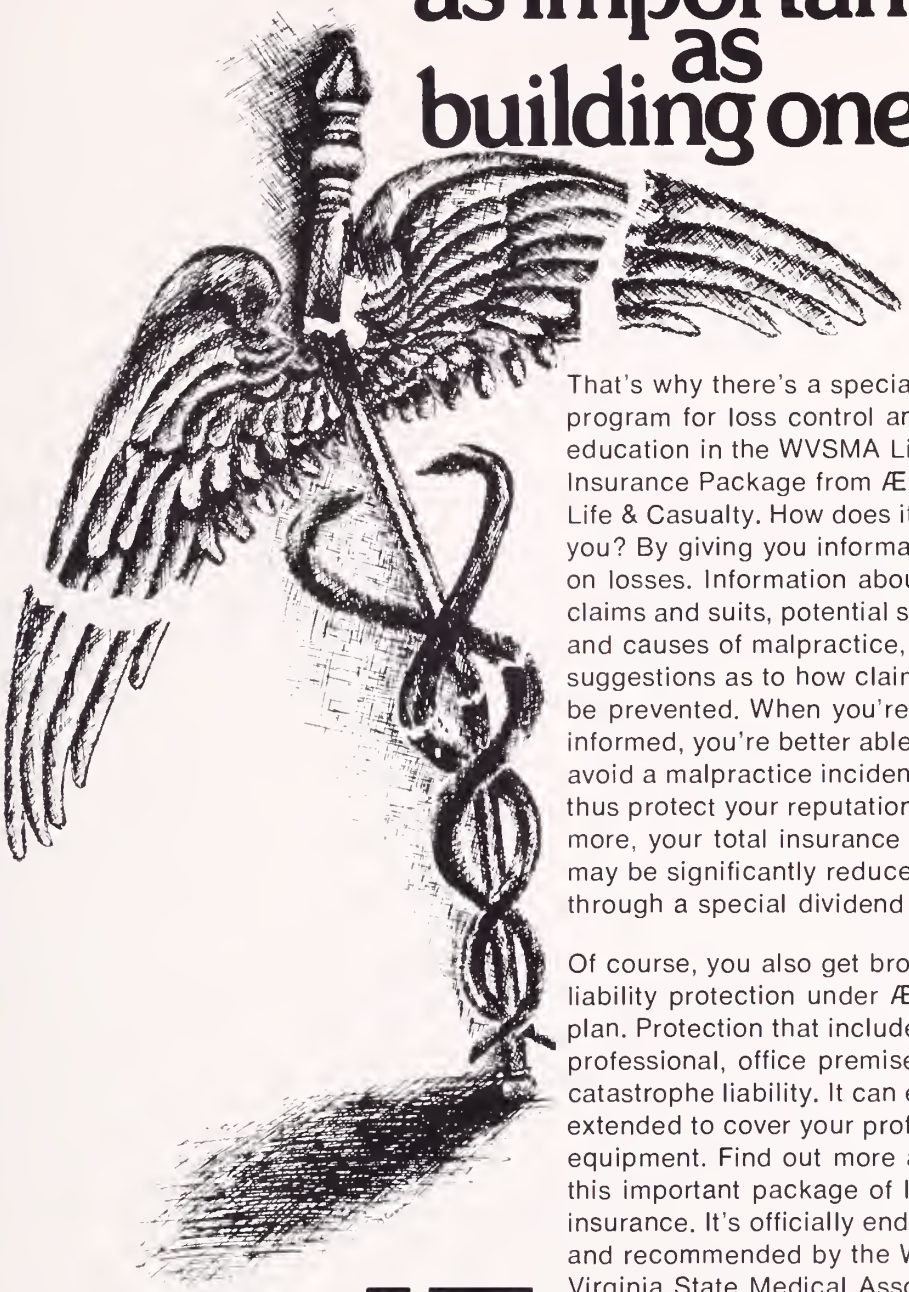
New Anesthesiology Professor

One associate professor has been added to the faculty of the Department of Anesthesiology, West Virginia University School of Medicine.

She is Jeanne Andrew Rodman, a native of Nevada, Iowa, and a graduate of Drake University.

Receiving her M. D. degree from the University of Iowa, Doctor Rodman was an Instructor in Anesthesiology at the University of North Carolina before returning to Iowa as an assistant professor.

Protecting a reputation is as important as building one.



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The Month in Washington

• **From the Washington Office of the American Medical Association.**

THE Senate has overwhelmingly passed legislation that would require one-fourth of all medical and dental school graduates to spend at least two years in the nation's slums and rural areas where there are shortages of physicians.

Earlier the Senate voted down a much more sweeping bill sponsored by Sen. Edward Kennedy that would have required mandatory federal service for all health professions students and national licensure and relicensure for physicians and dentists.

Hours before the first Senate vote Senator Kennedy, aware that he was losing liberal support, shelved his Health Subcommittee's $5.1 billion, five-year bill and offered a substitute measure which was trounced 57-34. Instead, the Senate adopted a measure sponsored by Sen. J. Glenn Beall, Jr., (R-Md.) and went on to pass a three-year, $2 billion health manpower bill by a vote of 81-7.

The bill finally approved by the Senate was stripped of most of the controversial provisions of the original Kennedy bill and was a victory for the American Medical Association, the American Dental Association, and the Association of American Medical Colleges.

The Senate bill calls for a three-year extension of present federal programs for aiding medical education at a total cost of about $2 billion. Capitation grants for medical schools would be continued at a high level despite the administration's request for a cutback.

The Beall substitute measure provides federal aid to medical and dental schools that agree to allocate 25 per cent of their classroom space to students volunteering to serve in areas short of medical care workers. In return for either civilian or federal service under the National Health Service Corps, the students would receive scholarships.

The Kennedy bill would have compelled all medical school graduates to serve in the shortage areas, an approach labeled a "domestic draft" by Senator Beall and his committee colleagues, Sens. Peter Dominick, (R-Colo.) and Robert Taft, Jr., (R-Ohio), who developed the substitute measure.

The Senate bill does not contain the original requirement for a federally-appointed National Council on Postgraduate Education with 10 regional councils designed to deal with allocation of specialty training slots and foreign medical graduates. The senators contended this was too heavy an involvement of the federal government.

Another casualty of the Senate voting was the proposal for federal standards for licensing and re-licensing physicians and dentists, a plan that stirred wide protest within the professions.

The Maryland Senator's bill represented a middle ground on financial help for medical schools, with the AAMC contending the amount was too low and the Administration believing it was too high.

Immigration standards would be tightened to restrict the number of foreign medical graduates under the Senate bill.

Counterpart Bill in The House

On the other side of the Capitol, a House subcommittee has approved a counterpart bill to the Senate manpower legislation that would establish federal scholarships intended to increase the number of doctors in the nation's rural areas and urban slums where there are doctor shortages.

The House subcommittee's bill authorizes $240 million over three years for National Health Service Scholarships paying $9,200 to $9,500 a year to cover the cost of a medical education.

In return, the scholarship recipients would have to spend two to four years serving in areas with doctor shortages. Non-scholarship students who volunteer to practice in areas with doctor shortages would receive a guaranteed income of $28,000 a year until they get their practice started. The bill would also give medical schools a grant of $2,100 a year for each student — $400 less than the schools now receive.

But any graduate who does not practice in an underserved area would have to repay the government the money given to the medical school.

Though the House bill differs sharply from the Senate version, particularly the Senate provision forcing medical schools to have one-fourth of their classes on federal scholarships requiring two years of practice in underserved areas, the House subcommittee Chairman, Paul G. Rogers, (D-Fla.), believes the difference can be resolved when the two bills go to conference.

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Obituaries

AUSTIN A. PROVINS, M. D.

Dr. Austin A. Provins of Key Biscayne, Florida, formerly of Morgantown, died on August 25 at his home. He was 43. A native of Morgantown, Doctor Provins was graduated from West Virginia University and received his M. D. degree in 1955 from the University of Pennsylvania School of Medicine. He interned at Letterman Army Hospital in San Francisco.

Doctor Provins practiced in Morgantown from 1957 to 1963, when he moved to Florida. At the time of his death he was employed by the Veterans Administration Hospital in Miami, Florida. He was a member of the Monongalia County Medical Society, the West Virginia State Medical Association, the American Medical Association and the Florida Medical Association.

Survivors include four children, Pamela, Judith, Austin J. and Philip Provins, all of Fresno, California; and two sisters, Mrs. W. Ray Waters of Morgantown and Mrs. William McVay of Pittsburgh.

JULIUS L. BERKLEY, M. D.

Dr. Julius L. Berkley, Charleston surgeon, died on September 16 at his home. He was 62. Doctor Berkley was a member of the medical staff of the Charleston Area Medical Center, where he was Chief of the Section of Proctology, and of the staffs of Kanawha Valley Hospital in Charleston and Herbert J. Thomas Memorial Hospital in South Charleston.

Born in Baltimore, Maryland, Doctor Berkley received his M. D. degree in 1938 from the Medical College of Virginia. He served his internship and residency at Charleston General Hospital. He was certified in surgery and in colon and rectal surgery.

Doctor Berkley was a Fellow of the American Proctologic Society and the American College of Surgeons. He served for three years with the U. S. Army Medical Corps during World War II. He was a member of the Kanawha Medical Society, the West Virginia State Medical Association, the American Medical Association and the Southern Medical Association.

Surviving is the widow.

GEORGE E. STROBEL, M. D.

Dr. George E. Strobel of Wheeling, retired family physician and surgeon, died on September 8 in a Wheeling Hospital. He was 74. A native of Wheeling, Doctor Strobel was graduated from Bethany College, the two-year West Virginia University School of Medicine, and received his M. D. degree in 1933 from Rush Medical College.

He served his internship at Ohio Valley General Hospital in Wheeling and later was on the surgical staffs of Ohio Valley General and Wheeling Hospital.

Doctor Strobel was a member of the Ohio County Medical Society, the West Virginia State Medical Association, the American Medical Association and the International College of Surgeons.

Survivors include the widow; a son, Dr. George E. Strobel, Jr., of Philadelphia; and a daughter, Mrs. John C. Schenk of Bettendorf, Iowa.

GERALD E. HARTLE, M .D.

Dr. Gerald E. Hartle of Philippi died on October 6 in a Winchester (Va.) hospital. He was 59. A native of Leitersburg, Maryland, Doctor Hartle received his M. D. degree in 1941 from Loma Linda University School of Medicine in California.

Doctor Hartle began family practice in Moorefield, then specializing in anesthesiology in Philippi for the past 12 years. He was a member of the Tygart's Valley Medical Society, the West Virginia State Medical Association, the American Medical Association and the American Society of Anesthesiologists.

He is survived by two sisters, Miss Hazel B. Hartle and Miss Dorothy B. Hartle; and two brothers, Joseph E. Hartle and Ralph C. Hartle, all of Hagerstown.

STATEMENT REQUIRED BY THE ACT OF OCTOBER 23, 1962; SECTION 4369, TITLE 39, UNITED STATES CODE SHOWING THE OWNERSHIP, MANAGEMENT AND CIRCULATION OF THE WEST VIRGINIA MEDICAL JOURNAL.

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(Signed) William H. Lively,
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Committee on Aging*

This is the fifth report to be presented by this Committee on Aging to the West Virginia State Medical Association.

The Transportation Stamp Program for the aging and physically handicapped now called T.R.I.P. was officially announced by Governor Arch A. Moore, Jr., at our open meeting in the State Capitol, June 13, 1974. A special appreciation for sowing the seeds for the new program was expressed by the Hon. Edwin F. Flowers, Commissioner of Welfare to Dr. Eldon B. Tucker, Chairman of the Committee on Aging of the West Virginia State Medical Association. This program is now in its infancy. With careful planning it can be made to work. The following quotation is taken from the 1973 report of the Committee on Aging: "The Governor is to be commended for taking the initiative in providing this worthwhile service."

There is still an absence or shortage of physicians in some rural sections of West Virginia. The young physician who has been trained to be a specialist will not locate in a small community.

There must be some special reason or inducement for any young physician, general practitioner or specialist to locate in a rural community. I will mention some; home, birthplace, parents, wife, children, schools, church, nearness to a medical center and a personal dedication to serve people. The Chairman would like to quote from a letter from one of his classmates concerning two of his classmates. *Quotes*: "The man who in my opinion had the highest ideals, the greatest love of humanity, and of his profession was Harold Miller. I am happy to say that he was my best friend. He came from an isolated village named Eglon in West Virginia whose inhabitants consisted mostly of an old Protestant religious sect known as Dunkards. Following graduation I said to him, "Harold, now that you have probably gained more medical knowledge than any other man in our class, how do you propose to become famous in your profession? No, Floyd, he said as soon as I have finished my hospital training, I am going back to Eglon to practice. The people need me there so much.. About six years later a middle aged woman walked into my office in Canton, Ohio, stating that her home address was Eglon, West Virginia. She said that Drs. Harold and Blanche Miller were the most loved couple in the Hills of West Virginia."

This quotation illustrates the dedication and the respect which existed between the family physician and the patient 50 years ago.

The following letter is from John W. Traubert, M.D., Professor and Chairman, Department of Family Practice, West Virginia University Medical Center, July 11, 1974:

Dear Doctor Tucker:

The Department of Family Practice at West Virginia School of Medicine is now a reality with residents in training. We have four physicians in training at the first-year level and one in the second-year level.

Our Family Practice Model Unit consists of a 6,200 square foot office equipped with eight examining rooms, a minor surgery room, four consultation rooms and an adequate library and laboratory. The unit is unique in that we are also incorporating Family Dentistry into our total health care delivery concept.

Within two years we will be able to give to the State of West Virginia four trained physicians who will be board eligible in Family Practice. These physicians, coupled with the graduates of the programs at Thomas Memorial Hospital in Charleston and the one at Wheeling Hospital in Wheeling, will turn out 12 physicians in Family Practice annually within the two to three year period.

Part of our training includes Geriatric care. Both in the Ambulatory Care Center and in Nursing Homes throughout the area. We feel that the product of our training program will have more insight and empathy toward the aging patient than any existing program in the State.

The aging will benefit much from the training of family physicians. No other discipline of medicine has included a training period specifically in Geriatric Medicine such as we have incorporated into our training program.

There is no immediate answer to problems of the aging or to the medical care of remote areas in the State. We do offer a hope for the future.

Sincerely,

(s)John W. Traubert, M.D.

Two years ago we recommended that the Department of Welfare be requested to prepare a booklet explaining in detail all of the benefits to which the Aging Citizen is eligible or entitled.

Doctor Traubert has spoken concerning the Family Practice Program. John E. Jones, M.D., Dean of the School of Medicine, addressed the following letter to me dated July 16, 1974. His report includes the Family Practice Program and the wider range of medical education and training of physicians for the whole state.

Dear Dr. Tucker:

As you requested in our recent conversation, I am sending this note along to you to indicate the actions the School of Medicine has undertaken that we feel will help retain ours and other graduates in the State of West Virginia and strengthen medical care in the State as well.

A major step forward is the development of a full accredited program in Family Practice at West Virginia University in Morgantown. As you know the School of Medicine now has Divisions in Charleston and Wheeling, West Virginia. The Charleston Program is underway now under the auspices of an A.H.E.C. Grant. There our main emphasis is in establishing a Family Practice Program plus support for the five major departments required for an accredited Family Practice Program (Medicine, Psychiatry, Pediatrics, Obstetrics and Gynecology, and Surgery). The affiliation with the University also greatly aided in gaining full accreditation for the established residencies already

*Other annual reports were published in the August, 1974 issue of **The Journal.**

in existence. The A.H.E.C. Grant also contains other important facets such as continuing education, paramedical education, consumer education, etc.

The Divisional Programs will have a small number of fulltime faculty to oversee the educational programs and to organize and coordinate the major contributions to be made by the faculty in the Charleston and Wheeling areas. As both the Charleston and Wheeling programs get underway we believe that these will represent an excellent nucleus for continued communication and education for practicing physicians within several miles of these regions. The protection and development of fully accredited postgraduate training programs in Family Practice (Wheeling's Program is also approved) and other primary care specialties should greatly aid in retaining ours and other graduates in the State. As I told you 17 of last year's graduating class are in postgraduate programs in the Charleston area this year. Other graduates are in the Wheeling program as well. We have attracted some gifted teachers in several of the programs in both the Wheeling and Charleston area. We expect them to have an increasing impact in influencing our graduates to stay in these programs.

As I told you one of the best correlations to where a graduate M.D. sets up practice is where he finishes his training. Thus, we feel very strongly about the growth and development of our Divisional Programs. We also feel very strongly that these two programs (and perhaps others to be developed) will represent an outstanding clinical experience for our students and will be especially important should the Medical School increase its class size.

We feel that we should offer a medical education to the qualified West Virginia natives. At the moment it would appear that there would be approximately 120 potential Medical School Students each year. Whether the Medical School expands from its current 84 per class size to any other larger number is an economic and political question that must be answered by the citizens through their regularly elected representatives. As I told you we are in need of modest expansion of both the space for basic sciences as well as some new faculty people. The growth and development of our current divisions will also be dependent upon appropriation of new State dollars to support these programs.

The School of Medicine also recognizes its obligation to have an important role in Continuing Medical Education. Significant activity in the Kanawha Valley where a large percentage of the population can be contacted is already underway through the Division of the School of Medicine at Charleston. We hope to develop adequate funding to expand the current role that the School of Medicine plays in Continuing Medical Education as well. We feel strongly that such a program would also aid in retaining our graduates in the State.

I would like to emphasize again what I think is very significant progress in the complete activation of Family Practice Programs at Morgantown, Charleston and Wheeling. We are dedicated to the support of these programs and of the five parent departments that the Boards of Family Practice require in order to accredit their programs. We believe that we will see an increasing number of our graduates go into practice in and around the three major zones of medical education in West Virginia (namely Morgantown, Charleston and Wheeling). As you well know a number of our completed residents and graduates have just entered practice in Morgantown in the last month or two. All four of the new internists in practice in town completed their residency training at WVU. Three of the four are graduates of our School. Similar comments apply to two of the three surgeons and a number of the family practitioners now in Morgantown.

I am convinced that we will see an increasing number of our graduates returning to practice in West Virginia. As I told you it takes a number of years following graduation from medical school to be able to accurately assess where these M.D. graduates will end up in practice. Certainly the impact on the care for the aged as well as other segments of our population will be greatly benefited by the increasing availability of medical care. We are thoroughly aware that socio-economic improvements must occur at the community level to entice our graduates or other professional graduates to those areas. Again, we think the development of strong centers for continuing education and graduate education in and around the State will greatly strengthen the possibility of enticing our graduates to stay in and around each of these areas.

I hope this is the sort of information that you wished.

Sincerely yours,
(s)John E. Jones, M.D.

The Family Practice Program will help to solve the shortage of general practitioners but it will not be noticeable before 1980. In the meantime the aging person needs his own family physician. He should take influenza shots. He should have a routine checkup and should follow his physician's advice. He should have a hobby. He should take daily reasonable exercise. He should control his weight by dietary means. Blood pressure today is on the air. He should have it taken repeatedly if it is above or below the average normal.

Last year we recommended that fourth-year medical students be invited to attend the Annual Meeting of the West Virginia State Medical Association. If this would be too expensive, then individual physicians should be urged to invite members of the graduating class who might be considering locating in West Virginia as their guest.

The number of aging citizens is increasing. They nearly all receive Social Security Benefits and have limited hospital and medical protection under Medicare. Additional hospital insurance is needed. Limitation of hospital stay penalizes the aging. More out-patient care and more drugs should be provided. More extended care facilities or nursing homes should be provided. The cost should be reasonable. If not for the long-stay patient, it should be largely subsidized under Medicare.

The family physician is still important to the aging. He is the leading citizen in the small community. All go to him for advice. The story of Drs. Harold and Blanche Miller illustrate what it means to be a family physician in a small community.

Respectfully submitted,
Eldon B. Tucker, M. D.
Chairman
Myer Bogarad, M. D.
Richard D. Hamilton, M. D.

County Societies

CABELL

The Cabell County Medical Society met on September 12 in Huntington at the Collonade Restaurant. A moment of silence was observed in memory of the late Dr. Ray M. Bobbitt, a Past President of the State Medical Association.

Dr. Edwin J. Humphrey, III, President, commended the Society for its participation in a television series created by the American Cancer Society. Particular commendation was given to Dr. Tara Sharma for his contribution of time and effort.

The Society unanimously passed a resolution calling for a more complete and detailed financial statement of the State Medical Association. Such financial statement would be submitted in writing semi-annually by the Treasurer to the Council for inclusion in the minutes of the Council meetings, and the annual audit by a disinterested reputable accounting firm would continue to be performed each year and published in *The West Virginia Medical Journal.*

(Please refer to Page 308 in this issue for a report on action taken on this subject by the Council during a meeting held on October 6).

The Society next met on October 10 at the Gateway Inn in Huntington. Dr. Robert C. Parlett, Dean of the Marshall University Medical School, was the speaker. Doctor Parlett discussed the early development and planning of the medical school.

Doctor Jack Leckie announced that initial work had been started toward establishing a family practice residency at St. Mary's Hospital in Huntington. He also extended thanks to the Society for its support in having him named President Elect of the State Medical Association.—Charles H. McKown, Jr., Secretary.

HARRISON

The Harrison County Medical Society met on September 12 in Clarksburg. The guest speaker was Dr. William E. Gilmore of Parkersburg, President of the West Virginia State Medical Association. Doctor Gilmore's topic was "Emergency Medical Services in West Virginia."

There was discussion on a clinic program in which school nurses would take a student's blood pressure.—Julian D. Gasataya, M. D., Secretary.

MERCER

The Mercer County Medical Society met on September 16 at the University Club in Bluefield. A movie on atherosclerosis was presented by Dr. James P. Thomas of Bluefield. Hyperlipidemia, elevated glycerides and cholesterol were discussed.

It was announced that Dr. John J. Mahood of Bluefield had been elected Vice President of the State Medical Association. Dr. Hawey A. Wells, Jr., of Princeton discussed the American Medical Association Physician's Recognition Award and urged all members to complete qualifications for the Award.—John J. Mahood, M. D., Secretary.

MONONGALIA

Dr. William E. Gilmore, President of the West Virginia State Medical Association, was guest speaker for the meeting of the Monongalia County Medical Society on September 3 at the Lakeview Inn and Country Club near Morgantown. Doctor Gilmore, Parkersburg surgeon, spoke on "Emergency Medical Services in West Virginia." His talk was well received. Following his presentation, the Society stood for a moment of silence in tribute to the late Dr. Austin A. Provins, Jr., who was a long-time member of the Society.

The Society approved a resolution introduced by Dr. Eldon B. Tucker of Morgantown approving the T.R.I.P. Program and requesting that the County Court and officials of the city government use every means at their disposal to make it possible for senior citizens and the physically handicapped of the county to avail themselves of the transportation services under the program. Copies of this resolution were to be sent to the Secretaries of the component medical societies.— H. Summers Harrison, M. D., Secretary.

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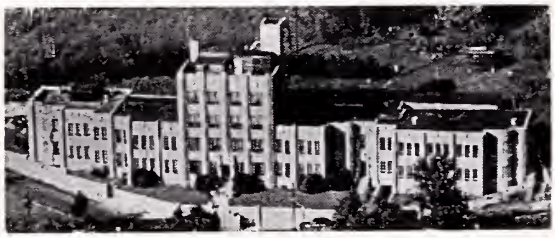

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B. G. Thimmappa, M. D.
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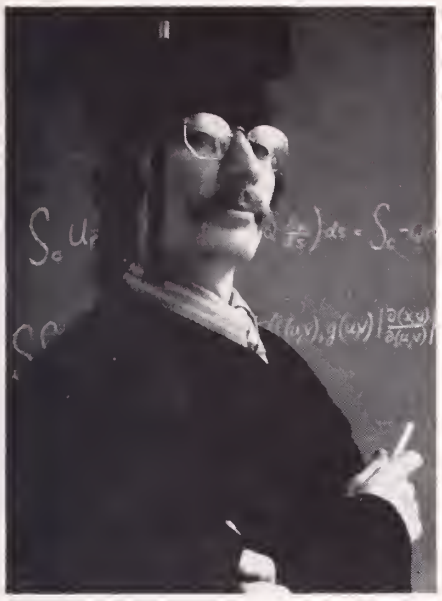

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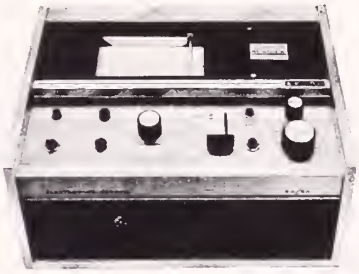

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

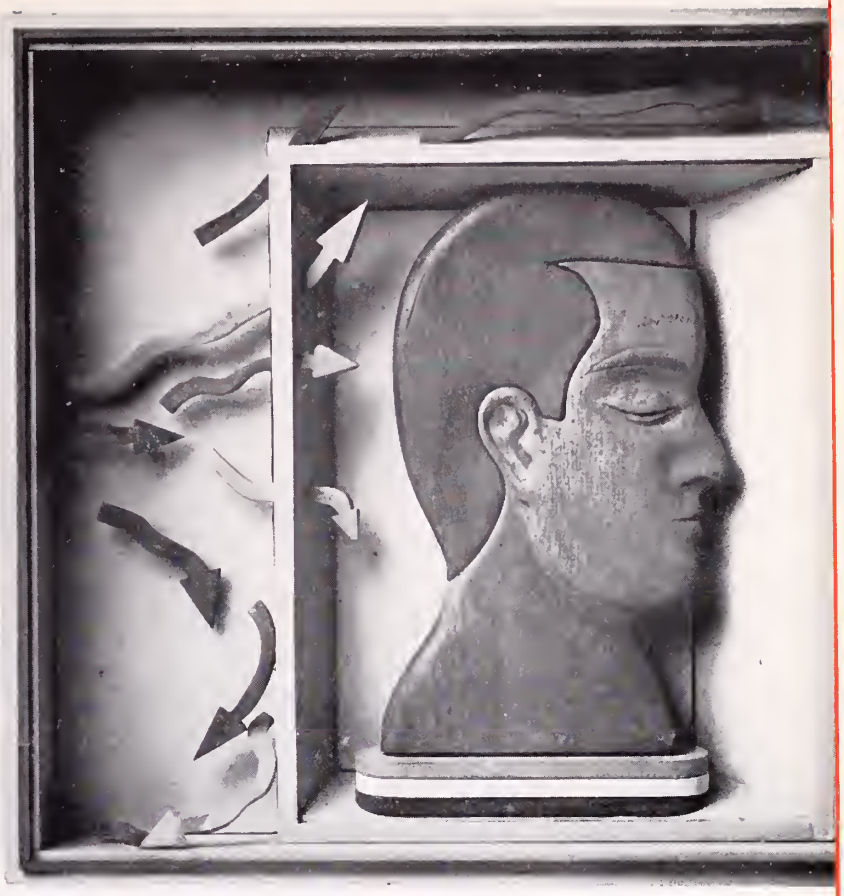
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize t maximum beneficial effects. *Oral—Adu* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, or 25 mg *t.i.d.* or *q.i.d. Geriatric patient* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

Supplied: Librium® (chlordiazepox HCl) *Capsules*, 5 mg, 10 mg and 25 mg —bottles of 100 and 500; Tel-E-Dose® packages of 100. Libritabs® (chlordiazepoxide) *Tablets*, 5 mg, 10 mg and 25 n —bottles of 100 and 500. With respect t clinical activity, capsules and tablets ar indistinguishable.



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to help reduce clinically significant anxiety an thereby help improve patient receptivity

Librium® up to 100 mg daily in severe anxiety (chlordiazepoxide HCl)

Please see following pag

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The patient may have difficulty in accepting medical counsel.

Clinical experience has shown that some unduly anxious patients may tend to deny or minimize their illness and therefore resist seeking or following medical advice. Through its antianxiety action, adjunctive Librium (chlordiazepoxide HCl) can often calm the emotionally tense patient, thereby encouraging physician patient rapport and, on occasion, making it easier for the patient to accept medical counsel.

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(chlordiazepoxide HCl)

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Please see reverse side
for summary of product information.

the West Virginia Medical Journal

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70 No. 12

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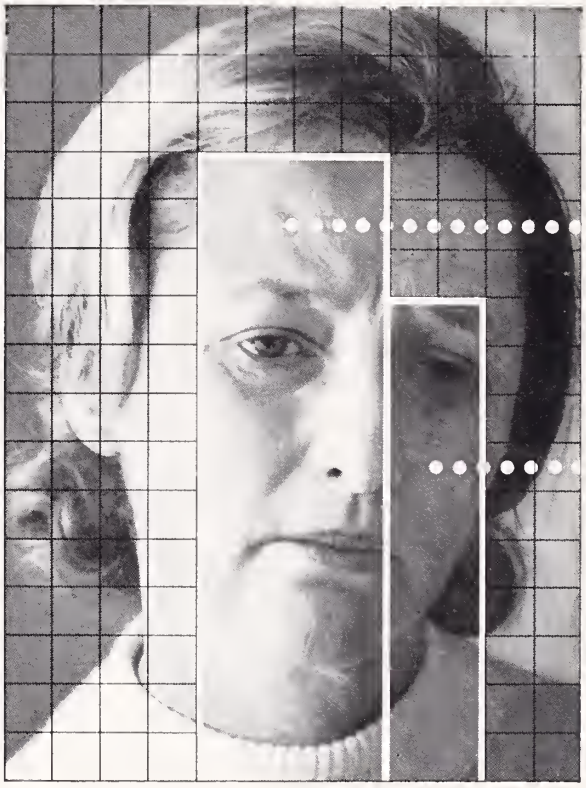

Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in fr and/or severity of grand mal seizu require increased dosage of stand convulsant medication; abrupt wit may be associated with temporary crease in frequency and/or severi seizures. Advise against simultane gestion of alcohol and other CNS d sants. Withdrawal symptoms (sim those with barbiturates and alcoho occurred following abrupt disconti (convulsions, tremor, abdominal a cle cramps, vomiting and sweating addiction-prone indlviduals under

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two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

For further information on this subject, the following references are provided:

1. Henry BW, *et al: Dis Nerv Syst 30*:675-679, Oct 1969.
2. Hollister LE, *et al: Arch Gen Psychiatry 24*:273-278, Mar 1971.
3. Claghorn J: *Psychosomatics 11*:438-441, Sept-Oct 1970.

Valium® (diazepam)

2-mg, 5-mg, 10-mg tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

because of their predisposi-
uation and dependence. In
lactation or women of child-
, weigh potential benefit
sible hazard.

: If combined with other psy-
r anticonvulsants, consider
armacology of agents em-
gs such as phenothiazines,
arbiturates, MAO inhibitors
tidepressants may potentiate
sual precautions indicated in
erely depressed, or with latent
or with suicidal tendencies.

Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

DECEMBER
1974

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Charleston

EXECUTIVE ASSISTANT
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BS–SB

Breast self-examination:

KEY ROLE OF THE PHYSICIAN

item:	**Breast cancer is a major concern of American women, according to a recent Gallup study conducted for the American Cancer Society.**
item:	**Although aware that early discovery improves the chances of cure, and that BSE can lead to early discovery, *fewer than 1 in 5* women practice BSE, and *only half* have an annual breast examination by a physician.**
item:	**Only 35% of all women polled reported that a *physician* had ever raised the subject of breast self-examination, and only 24% had received instruction from the physician on how to do it. Even among women who regularly see a gynecologist, only 34% had been instructed on BSE.**
item:	***But,* among women who received personal instruction from their physicians, the overwhelming majority *(92%)* practiced BSE during the preceding year.**

The Gallup study revealed that, far more important than increasing awareness of breast self-examination, is the problem of inducing women to practice it regularly. The physician plays a key role in this—by teaching women the correct technique, and instilling in them the confidence that will assure their continued practice of BSE.

The American Cancer Society gives major emphasis to breast cancer through research and a vast array of public educational materials, designed to give women life-saving information about the disease. Our latest approach is via a pioneering television film starring Jennifer O'Neill, "Breast Cancer: Where We Are." Where we *will* be in a few years will certainly hinge on our joint efforts.

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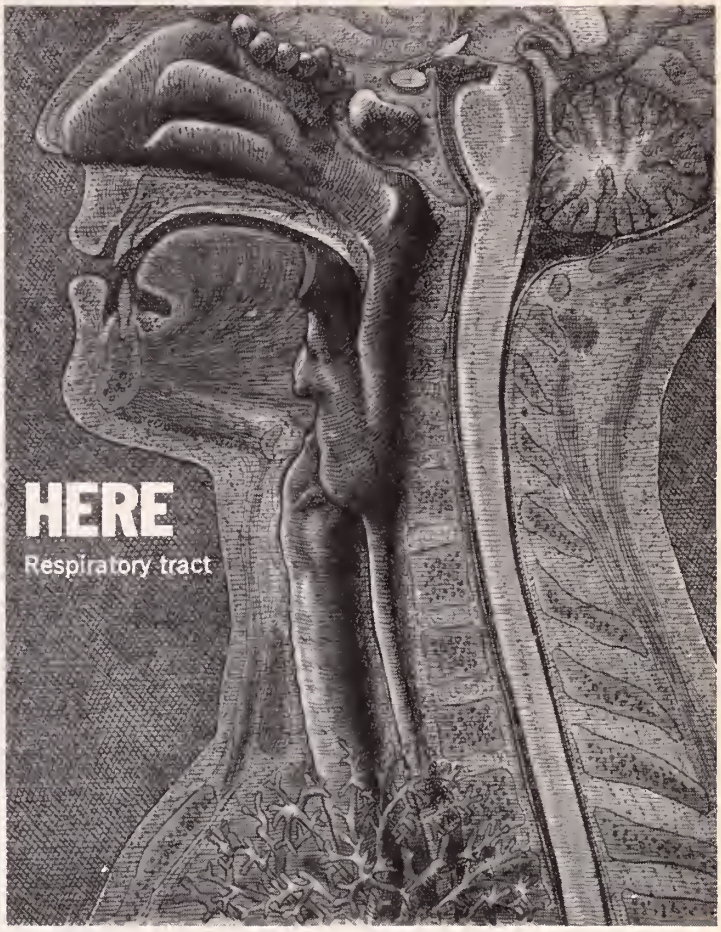

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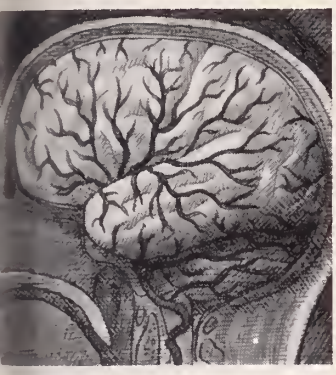

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The Role of the Detail Man

Opinion & Dialogue

Dr. Willard Gobbell
Family Physician
Encino, California

"I may be prejudiced, but I r very much in favor of the detail n I meet. Most of them are knowlec able about the drugs they promo and can be a great help in acqua ing me with new medication."

Family Physician's Perception

I think that most general practitioners in this area feel as I do about the detail man. Over the years I have gotten to know most f the men who visit me regularly a they in turn have become aware my particular interests and the n ture of my practice. They, therefore, limit their discussion as mu as possible to the areas of intere to me. Since I usually see the sar representative again in future visits, it is in his best interest to supply me with the most honest, factual, as well as up-to-date information about his products.

Dr. Jeremiah Stamler
Chairman
Department of Community Health and Preventive Medicine, and Dingman Professor of Cardiology
Northwestern University Medical School

"In the total picture of deal g with health problems in this cou there is a potential for detail mer to play a meaningful role."

The Positive Influence

My contact with representa tives and salesmen of the pharm ceutical industry is the type of co tact that people in a medical cen research people, and academic people have and that's in all likel on a somewhat different level fro that of the practicing physician.

Let me touch on how I perso ally perceive the role of the sales representative. These men reach large numbers of health professionals. Thus they could be—an at times actually are—dissemina tors of useful information. They could consistently serve a real ec cational function in their ability t discuss their products.

At present they do distribut printed material, brochures and pamphlets—some of it scientific ally sound and therefore truly us ful—as well as some excellent fil produced by the pharmaceutical industry. When they function in t

He a Source of Information?

Yes, with certain reservations. ıe average sales representative ıs a great fund of information ıout the drug products he is re-onsible for. He is usually able to ıswer most questions fully and telligently. He can also supply prints of articles that contain a eat deal of information. Here, ɔ, I exercise some caution. I usu-y accept most of the statements d opinions that I find in the ıpers and studies which come ɔm the larger teaching facilities. goes without saying that a physi-ın should also rely on other urces for his information on ıarmacology.

aining of Sales Representatives

Ideally, a candidate for the ısition as a sales representative a pharmaceutical company ould be a graduate pharmacist ıo has a questioning mind. I don't ink this is possible in every case, d so it becomes the responsibility of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

---

pacity they are indeed useful; ırticularly in the fact that they sseminate broadly based educa-ınal material and serve not just "pushers" of their drugs.

e Other Side of the Coin

Obviously, the pharmaceuti-l companies are not producing all 's material as a labor of love—ey are in the business of selling ɔducts for profit. In this regard e ambitious and improperly moti-ted sales representative can ert a negative influence on the acticing physician, both by pre-nting a one-sided picture of his oduct, and by encouraging the actitioner to depend too heavily drugs for his total therapy. In ese ways, the salesman has often storted objective reality and ıdermined his potential role as an ucator.

ıe Industry Responsibility

Since the detail man must be ı information resource as well as 'epresentative of his particular ıarmaceutical company, he ıould be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—*i.e.*, the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that information must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

Pharmaceutical Manufacturers Association
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Daniel Boone Hotel

Washington and Capitol Streets
Charleston, West Virginia

2 P.M. and 8 P.M. Friday, January 24
9:30 A.M. and 2 P.M. Saturday, January 25
9:30 A.M. Sunday, January 26

THE PROGRAM again will offer a wide-ranging clinical and educational experience for the practicing physician. FRIDAY AFTERNOON, January 24, session on heart diseases; FRIDAY EVENING, presentations will include PSRO's and a session open to the public on the "problems of adolescents." A medically oriented program on problems of adolescents will be held SATURDAY MORNING, January 25 with these other scheduled subject areas to follow: SATURDAY AFTERNOON, cerebral vascular diseases and diabetes; SUNDAY MORNING, January 26, pulmonary disease in adolescents, cancer and "How to Avoid Malpractice."

THE FACULTY will include outstanding specialists in their fields from various educational and other settings, both outside and from within West Virginia.

THE PROGRAM CO-CHAIRMEN again are Ralph H. Nestmann, M. D., and Joseph T. Skaggs, M. D., both of Charleston. Also on the Program Committee are William O. McMillan, Jr., M. D., of Charleston, and C. Carl Tully, M. D., of South Charleston.

THE REGISTRATION FEE of $15 for the entire conference will be charged all registrants except nurses, medical students, interns and residents. Advance registration is requested, and please make checks payable to "WEST VIRGINIA STATE MEDICAL ASSOCIATION."

ACCREDITATION: Attendance will be acceptable for Category 1 credit toward the Physician's Recognition Award of the American Medical Association; and the program also is expected to carry prescribed credit by the American Academy of Family Physicians.

OVERNIGHT ACCOMMODATIONS: Physicians should communicate directly with the reservation manager of the hotel or motor inn of their choice, with the conference headquarters hotel setting aside rooms for registrants.

FOR ADVANCE REGISTRATION, please complete the form below and mail to: WEST VIRGINIA STATE MEDICAL ASSOCIATION, P. O. BOX 1031, CHARLESTON, W. VA. 25324.

Please register me for the Eighth Mid-Winter Clinical Conference in Charleston, W. Va., January 24-26, 1975. My $15 registration fee is (is not) enclosed.

I will attend sessions at 2 P. M. Friday, January 24 ..... 8 P. M. Friday ..... 9:30 A. M. Saturday, January 25 ..... 2 P. M. Saturday ..... 9:30 A. M. Sunday, January 26 ..... All sessions .....

Name (please print) _____ *Specialty* _____

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CONTRAINDICATIONS: Aminophylline/Theophylline is contraindicated in the presence of severe cardiac arrhythmias and patients with massive myocardial damage. Ephedrine, in presence of severe heart disease, extreme hypertension, and in hyperthyroidism. Phenobarbital, in porphyria and in patients with known phenobarbital sensitivity. Potassium Iodide, in pregnancy (to protect the fetus against possible iodine-induced depression of thyroid activity), in tuberculosis (produces gumma dissolution), and in acne; also in the presence of known iodide sensitivity. PRECAUTIONS: Aminophylline/Theophylline should be avoided in patients with massive myocardial damage and/or severe cardiac arrhythmias. In children, overdose may cause vomiting, cardiac arrhythmias, and severe agitation. Ephedrine should be used with caution in the presence of severe cardiac disease, particularly arrhythmias and angina pectoris; avoid in hyperthyroidism and severe hypertension. Phenobarbital may be habit-forming. Avoid overdosage. Potassium Iodide: Discontinue in the presence of skin rash, swelling of the eyelids and severe frontal headache. Long use may cause goiter. ADVERSE REACTIONS: Aminophylline/Theophylline may cause nausea, cardiac arrhythmias, and aggravate severe myocardial disease. It may cause headaches and tachycardia. Vomiting and dizziness are not uncommon. Ephedrine: In patients hypersensitive to CNS stimulation, ephedrine may cause nervousness, tachycardia, extrasystole and ventricular arrhythmias. May cause urinary retention, especially in the presence of partial prostatic obstruction. Psychoneurosis may be aggravated. Pre-existing anginal pain will be aggravated. Phenobarbital may produce severe skin rash. Avoid overdosage. May be habit-forming. Potassium Iodide may cause nausea. Over very long period of use, iodides cause goiter. Discontinue if patient develops skin rash, eye irritation, eyelid swelling, or severe frontal headache.

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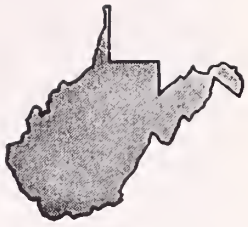

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The Urologic Management Of The Acutely Anuric Patient*

Stephen A. Stuppler, M. D.

The practicing physician is occasionally confronted with an acutely anuric patient. This clinical finding is a symptom of acute renal failure. When the preliminaries of history and a thorough physical examination have been completed, the diagnosis often still is in doubt.

Infravesical obstruction due to prostatic or urethral pathology must be ruled out as a cause of the anuric state. Anuria generally is not a disease amenable to surgical therapy.[1] On the other hand, surgically treatable causes for anuria must be considered when they exist.

While the outcome of this evaluation is usually disappointing, periodically one has the pleasant surprise of discovering a treatable cause for anuria. Three such cases, all of whom underwent successful urologic management, are presented.

Case 1

J. C., (H27-47-00), was a 58-year-old, white male who presented to the West Virginia University Medical Center with a one-week history of upper respiratory disease. He reported five days without urine output. There was a history of transient right flank pain approximately 10 days prior to admission. No other pertinent history was obtained.

Physical examination revealed a lethargic white male.

Pertinent laboratory results were: a blood urea nitrogen of 120 mg. per cent and serum potassium of 5.9 mEq. per liter. A plain film of the abdomen revealed two suspicious calcific densities (Figure 1). They were near the transverse process of the third lumbar vertebra on the left and in the right side of the pelvis.

On the basis of anuria and the possibility of a calculus etiology, he underwent cystoscopy under local anesthesia. Ureteral catheters were passed encountering resistance at the levels corresponding to the calcific densities seen on x-ray. A brisk post-obstructive diuresis ensued, and renal function tests revealed a normal blood urea nitrogen after 72 hours of catheter drainage.

The patient subsequently underwent left ureterolithotomy and the right ureteral calculus passed spontaneously. Serum and urinary evaluation for lithiasis was unremarkable. Follow-up pyelography revealed calcific densities over the kidneys but was otherwise normal (Figures 2a and 2b).

Case 2

W. O., (28-93-09), was a 63-year-old white male. He presented to the emergency room with a four-day duration of anuria. He was a poor historian due to his lethargic mental status. His family related that he had undergone a right nephrectomy in 1942.

The Author:

- **Stephen A. Stuppler, M. D., Department of Surgery, Division of Urology, West Virginia University Medical Center, Morgantown.**

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Figure 1. Plain film of the abdomen revealed two suspicious calcific densities near the transverse process of L_3 on the left and adjacent to the right ischial spine.

Figure 2a. Intravenous pyelogram. Follow-up plain film reveals calcific densities in the kidney.

Physical examination other than the previously mentioned lethargy was unremarkable.

Pertinent laboratory findings were: a blood urea nitrogen of 134 mg. per cent, serum CO_2 of 10 mEq. per liter and a potassium of 7.0 mEq. per liter. Electrocardiogram revealed atrial fibrillation. Plain film of the abdomen showed a 1.2 cm. opaque density in the left side of the pelvis (Figure 3).

Prior to cystoscopy the elevated serum potassium was lowered by treatment with intravenous insulin, glucose, sodium bicarbonate and kayexalate enemas.

Under local anesthesia a No. 5F ureteral catheter was passed cystoscopically to the left renal pelvis. A brisk hydronephrotic drip resulted and within 72 hours of catheter drainage, the blood urea nitrogen had dropped to 32 mg. per cent and the patient's sensorium had improved. He underwent ureterolithotomy and had an uncomplicated recovery.

Case 3

A. M., (28-54-95), was a 58-year-old white male. He was transferred to the WVU Medical Center after one week of hospitalization at another hospital. He was admitted there with vague and poorly characterized upper gastrointestinal symptoms. He was a mild diabetic under treatment with tolbutamide, 500 mg. daily. He had been noted to be anuric for four days prior to transfer to the WVU University Hospital.

Physical examination revealed a slightly obese white male without other pertinent physical findings.

Laboratory findings on admission revealed a blood urea nitrogen of 79 mg. per cent, potas-

Figure 2b. Intravenous pyelogram follow-up reveals non-obstructed kidneys.

Figure 3. Plain film of the abdomen shows a large calculus below the sacrum on the left.

Figure 4. Plain film of the abdomen revealed several calcific densities.

sium of 6.6 mEq. per liter, fasting blood sugar of 170 mg. per cent, hemoglobin of 10.8 gm. per cent, and a hematocrit of 33.3 per cent. Plain film of the abdomen revealed several calcific densities (Figure 4).

After initial evaluation by the medical service, he was catheterized and when an empty bladder was found, the urology service was consulted.

Under local anesthesia, he was cystoscoped and bilateral ureteral catheters (5-F) were passed (Figure 5). A brisk diuresis brought the blood urea nitrogen down to normal over a 36-hour period. It was believed that the patient might have had bilateral radiolucent calculi. After 48 hours, the ureteral catheters were removed and a drip infusion intravenous pyelogram was performed. The pyelogram revealed persistent obstruction (Figure 6). At this time, bilateral retrograde ureteropyelograms were performed revealing no intrinsic ureteral obstruction, but slight medial ureteral deviation (Figures 7a and 7b).

When extrinsic obstruction was diagnosed bilaterally, the patient underwent exploratory laparotomy. At surgery severe extensive retroperitoneal fibrosis was found. Ureterolysis was

Figure 5. Bilateral ureteral catheters in place. A brisk hydronephrotic drip ensued.

Figure 6. Drip infusion pyelography reveals persistent obstruction.

performed bilaterally from the renal pelvis to the distal ureter. Biopsy of the retroperitoneal tissue revealed no evidence of malignancy.

In addition to surgery, the patient was treated with prednisone, 60 mg. daily for a six-week period. Follow-up intravenous pyelogram was much improved (Figure 8).

Discussion

Although calculus disease of the urinary tract is a common-place occurrence, anuria due to stone is less common. In examining 654 cases of mechanical anuria, Proca found 80 cases due to calculus disease. Bilateral ureteral calculus anuria was even more rare occurring in only three of Proca's cases. Most of these cases presented with colic rather than the insidious findings of anuria or renal failure.[2]

Obstruction due to a solitary renal unit as in our second case represents a surgical emergency. In most cases we believe initially an attempt should be made at ureteral catheterization under local anesthesia. If successful, precious time can be obtained for correction of fluid and electrolyte imbalance created by the acute renal failure. Witness the 25 per cent mortality rate seen with patients upon whom emer-

Figure 7a (left). Right retrograde ureteropyelogram was performed revealing no intrinsic ureteral obstruction. A slight medial deviation of the middle one-third of the ureter was noted. Figure 7b (right). Left retrograde ureteropyelogram was performed revealing no intrinsic ureteral obstruction. A slight medial deviation of the middle one-third of the ureter was noted.

Figure 8. Follow-up intravenous pyelography at three weeks revealed resolving hydronephrosis, which was normal by six months follow-up time.

gency surgery had to be performed when conservative measures failed.[2]

The third case illustrated the uncommon and interesting phenomenon of retroperitoneal fibrosis. This entity is characterized by the development of a dense sclerotic inflammatory reaction in the retroperitoneum. There is usually progressive compression of anatomical structures in the retroperitoneal space.[3] Most authors report their patients are in the fifth, sixth and seventh decades and males outnumbered females two to one.[4] The patient usually presents either with renal or loin pain or more subtly with the insidious symptoms of renal failure.[5]

Most cases of retroperitoneal fibrosis are classified as idiopathic. Chronic usage of methysergide by migraine headache sufferers has been implicated as etiologic. Reversal of changes have accompanied discontinuation of medication. Ergotamine, dihydroergotamine and hydralazine also have been reported as etiologic factors.[4]

Therapy has been advocated to be combined medical and surgical. Initially ureterolysis is performed and followed by six to twelve weeks of prednisone therapy.[5]

Conclusion

These cases demonstrate that all anuric renal failures need not have a dismal prognosis. Prompt urologic evaluation is required to separate surgically treatable and medically treatable renal failure. When obstructive uropathy—whatever the cause—is found, treatment must be immediate and vigorous to effect a successful outcome.

A list of references may be obtained by writing The Journal.

President Urged To Insure Medicinal Supply

THE American Medical Association has urged President Ford "to take whatever steps necessary to assist in the procurement of raw opium from the world market." In a letter to President Ford, AMA President Malcolm C. Todd, M.D., said the illicit use of drugs should be vigorously combated by legislation and regulation but that "some opium products are essential in medical practice and an adequate supply of these agents for legitimate medical needs must be assured."

The AMA also urged that another type of poppy — papaver bracteatum — be cultivated in the U. S. in sufficient quantity to make the nation independent of outside sources. "This poppy," said Doctor Todd, "yields material that can be converted to codeine, a drug of low addiction potential, and cannot by any process known be converted to morphine or heroin. An adequate domestic crop of papaver bracteatum could be an important factor in the control of opium production and its diversion to illicit uses."

Direct Clinical Ocular Steady Potentials And The Intraocular Pressure

Carroll Dunn, B.S.; A. J. Magee, M.D.; And William S. Randall, B.S.

STEPANIK[1] studied the relation of the intraocular pressure (IOP) to the ocular steady potential (OSP), using the electro-oculogram, an indirect method of recording the OSP. Noell[2] described the effect of certain drugs on the OSP in the rabbit. Since acetazolamide, epinephrine and diisopropyl flurophosphate are widely used in glaucoma therapy, Noell's studies give information about the OSP and, by inference, the IOP.

In 1969, Dunn and associates[3] reported a clinical method for the static recording of the OSP. Beggren[4] and Cole[5] described the electrical potentials associated with active transport of sodium ions in animals.

The purpose of our study was to discover whether or not a relation exists between the IOP and the OSP as described by Dunn[3] and associates.

The Authors:

- **Carroll Dunn, B.S., Union Carbide Corporation Technical Center, South Charleston, West Virginia.**
- **A. J. Magee, M.D., Eye Department, St. Francis Hospital, Charleston, West Virginia.**
- **William S. Randall, B.S., Bechtel Power Corporation, San Francisco, California.**

Materials and Methods

We studied two groups of patients:

Group 1—The Control Group. Each subject met the following requirements: no personal history or family history of glaucoma, no eye diseases found during mydriatic examination and refraction, receiving no medication of any kind, and no systemic disease at the time of study.

Tracings were done only once on 100 of these patients and they were over 40 years of age. Tracings were done 10 times each on another 10 eyes: the ages here were 12 to 18. Lastly, tracings were done three times each on 10 more eyes: the ages varied from 12 to 55 in these patients. Except for a few measurements with the Halberg tonometer, all were made with the Goldmann applanation tonometer. One hundred-sixteen patients made up this group.

Group 2—The Glaucoma Group. These patients had IOP's of 41 mm. Hg. or more. Most

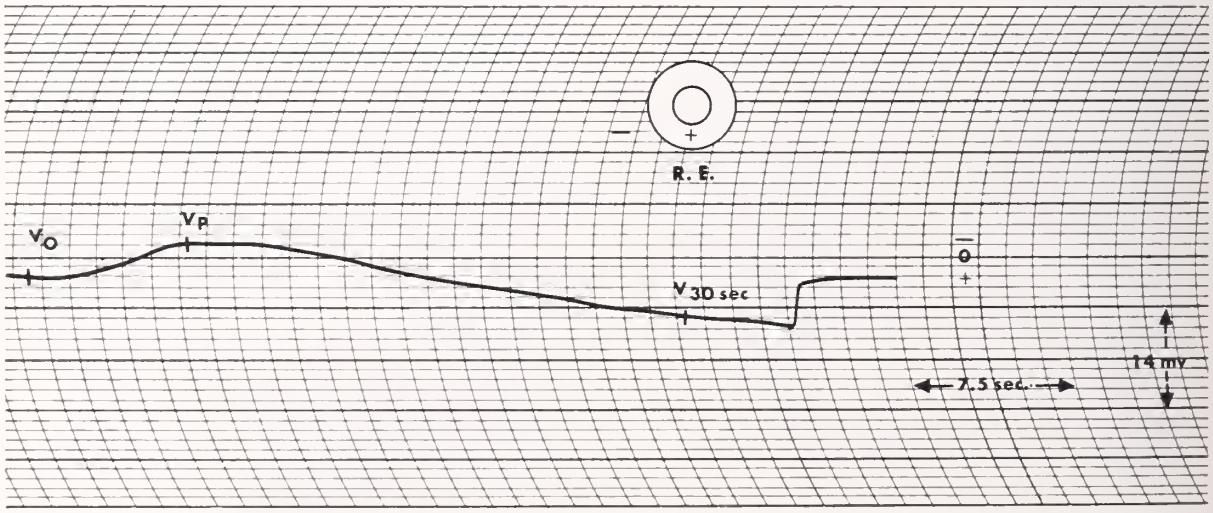

Figure 1. Ocular steady potential control tracing (from left to right). The circular figure represents the cornea and the placement of the electrodes. VO is the voltage at the beginning of the tracing. VP is the voltage at the peak of the tracing. V30 sec. is the voltage after 30 seconds.

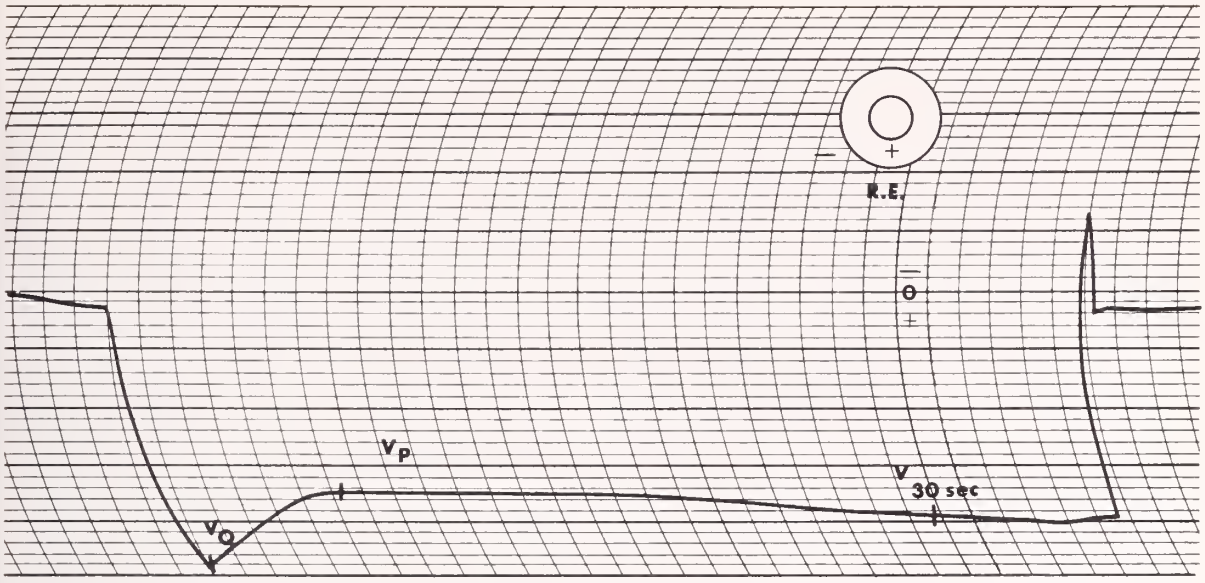

Figure 2. Ocular steady potential tracing from the right eye of a patient with an intraocular pressure of 54 mm. Hg. in each eye.

of the measurements were with the Goldmann applanation tonometer; a few were with the Schiotz.

Except that the basic technique was modified from a static to a sustained recording, the method and apparatus were as Dunn and associates described. After preparation as for routine tonometry, the patient was asked to fixate a light on the ceiling. The electrodes were placed on the globe gently but firmly. A foot-switch shorted out the circuit while the electrodes were taken from the bath and placed on the globe. When the electrodes were in position, the foot switch opened the circuit. Usually, there was a recognizable deflection. After elapse of the desired time, the electrodes were removed from the globe and replaced in their bath. The foot switch then reopened the circuit (Figure 1).

What appeared to be reflexes between the two eyes necessitated doing the tracings on one eye one day and on the other eye another day. Because the electrodes always damaged the corneal epithelium, no tracing was repeated earlier than after 48 hours.

Results

The peak value (see addendum), determined by studying the beginning of the tracing (VO), the peak of the tracing (VP), and the tracing at 30 seconds from the beginning (V30 sec.) was most significant in evaluating the OSP tracing. Table 1 summarizes the tracings from Group 1, the 100 control tracings done once. Table 2 shows the results of repeating the tracings 10 times on the same 10 eyes but on different days. Here the tracings are predominantly positive in two eyes and negative in the remaining eight. To determine the patterns of predominantly negative and positive tracings, we studied each of 10 more eyes three times (Table 3). In all except two (eight per cent) of the 25 patients with IOP's of 41 mm. Hg. or more, the peak OSP value in *at least one eye* was outside the range of -0.70 mv. to -14.43 mv. The repeat tests in six patients gave consistent results (Table 4 and Figure 2).

Discussion

Since the peak value of the OSP gave the most consistent results, we selected it for detailed study.

In the control group (Group 1), the values varied markedly (Table 1) and did not agree with Noell's findings in the rabbit. Since Noell used general anesthesia and dissected the orbit, the circumstances surrounding his rabbit experiments were very different from our methods. Also, there probably was more damage to the corneal epithelium in the rabbit experiments,

TABLE 1

Selected Values of a Group of Control-Type Potentials (100 Eyes)

Voltage	Mean	S.D.
At Beginning of Tracing (V_o)	−2.95 mv.	7.04
At Peak of Tracing (V_p)	−7.27 mv.	6.26
After 30 Seconds ($V_{30\ sec.}$)	+2.39 mv.	5.93

TABLE 2

Peak Values (in mv.) of Tracings Repeated 10 Times on 10 Eyes on Different Days

	LR	LL	HR	HL	ER	EL	JR	JL	RR	SR
1.	+0.35	—2.80	—0.35	—8.40	—3.85	+7.00	+7.35	+1.75	—1.40	—21.00
2.	+0.35	+7.00	—3.15	—2.80	—6.65	—4.20	—11.55	—9.45	0.0	+6.65
3.	+2.10	—2.45	+2.80	—10.50	—3.15	—10.50	—12.60	—15.05	—10.15	—4.90
4.	—3.85	+4.90	—2.45	+1.40	—5.60	—8.05	+2.80	—0.35	—8.05	—16.80
5.	—2.45	+4.20	—5.60	—2.80	—12.25	—1.05	—11.55	—2.10	—24.85	—12.95
6.	+5.25	+5.60	—8.40	—3.85	—3.50	—1.75	—5.95	+1.75	—12.60	—21.70
7.	0.0	+4.55	—11.90	+2.80	—8.75	—3.15	—1.40	—9.80	—13.65	—3.50
8.	+11.20	0.0	—1.75	+2.10	—8.40	0.0	—7.35	—9.80	—5.25	—2.80
9.	+8.75	+1.40	+0.70	—3.15	0.0	—4.90	—7.70	—1.40	—21.00	—5.25
10.	+4.55	+8.40	+5.95	+1.40	+1.05	—4.90	—14.70	—30.80	—3.85	—8.40

which would eliminate for the most part the potential of this structure.

Study of the peak values in the 10 tracings in 10 different eyes (Group 1) demonstrated the manner in which the potential varies (Table 2), being either roughly negative 80 per cent of the time, or roughly positive 20 per cent of the time, or vice versa. Predominantly negative tracings occurred approximately 84 per cent of the time and predominantly positive ones about 16 per cent. This shows that the peak value of the OSP is neither narrowly limited nor in equilibrium.

Study of the peak values of the OSP in patients with an IOP of 41 mm. Hg. or more (Table 4 and Figure 2) disclosed that they differ from the findings in the control group. A few patients had values well beyond those of the controls, with very high positive peak OSP readings with very high IOP, or, in one case of low-tension glaucoma, a very low OSP peak value.

Nearly all readings in the glaucoma group were usually either positive or markedly negative. These findings corroborate current concepts of the electrophysiology of the epithelium of the ciliary body.[4,5] Tracings were not repeated 10 times in each eye in our Group 2. Nevertheless, since the same type of values occurred in 23 of the 25 patients (92 per cent), the values can be considered constant. Repeated finding of peak OSP values outside the range -0.70 mv. to -14.43 mv. suggests a non-control type of tracing.

The basic difference between a control eye tracing and the tracing of an eye with an IOP of 41 mm. Hg. or more is that the peak OSP value in the control varies considerably. It is positive and negative at different times, although predominantly negative. In the glaucoma group, the peak OSP value is almost constantly either positive or markedly negative.

Our findings suggest that the OSP tracings for patients with an IOP of 41 mm. Hg. or more is of the non-control type. When a non-control type of OSP tracing is found in patients with an IOP of less than 41 mm. Hg., it probably indicates the presence of glaucoma. All of our data indicate a strong relationship between the OSP and the IOP. This suggests that the OSP, as recorded in this study, is the true OSP.

TABLE 3

Predominant Potential Repeated Three Times in Each of 20 Eyes

Patient	Eye	Predominant Potentials
1. LM	RE	Positive
2. LM	LE	Positive
3. HM	RE	Negative
4. HM	LE	Zero
5. EM	RE	Negative
6. EM	LE	Negative
7. JM	RE	Negative
8. JM	LE	Negative
9. RM	RE	Negative
10. RM	LE	Negative
11. SM	RE	Negative
12. SM	LE	Negative
13. AM	RE	Positive
14. VS	RE	Negative
15. JH	RE	Negative
16. JH	LE	Negative
17. EW	RE	Negative
18. BB	RE	Negative
19. FM	RE	Negative
20. GM	RE	Negative

TABLE 4

Selected Values (in mv.) From Tracings of Patients With IOP of 41 mm. Hg. or more ("s" Indicates Schiotz Tonometry)

Patient	Eye	IOP	V_O	V_P	V_{30} sec.
1. GD	RE	59s	+5.25	−0.35	−0.35
	LE	59	+1.05	−7.35	−5.95
2. BS	RE	55	+10.50	+5.25	+8.75
	LE	57	+1.75	+7.00	+2.80
3. JC	RE	41	+3.15	+2.45	+8.40
4. MW	RE	31	+2.45	+1.40	—
	LE	46	+7.00	+9.80	+8.05
5. AS	RE	101s	+31.15	+22.40	+22.05
6. JW	RE	94s	+23.80	+17.50	+17.50
7. LJ	RE	37s	+12.25	−0.35	+6.65
	LE	47	+15.05	+1.05	+7.00
8. AM	RE	42	+9.80	+7.00	+8.40
	LE	43	−9.45	−16.45	−8.40
9. VS	RE	43s	+1.05	−11.90	−9.45
	LE	47s	−11.55	−18.20	−3.85
	RE	37s	−5.25	−9.10	−4.55
	LE	47s	+1.75	−8.05	−1.40
10. JH	RE	51s	−1.05	+8.40	−7.70
	LE	34s	+10.85	+3.85	+4.20
11. CF	RE	55s	+4.20	−2.45	+5.95
	LE	59s	−1.75	+0.35	+6.65
	RE	30	−1.40	−7.00	+0.35
	LE	64	+2.45	−1.75	+7.00
12. SR	RE	54	+4.55	−0.70	0.0
	LE	32	+10.50	+5.95	—
	RE	59s	+2.10	−0.70	+3.50
	LE	29s	+10.85	0.0	+2.45
	RE	53	+3.85	+3.85	+5.60
	LE	40	+0.70	+0.70	+7.35
13. JCW	RE	57	+23.80	+8.40	+9.10
	LE	58	+5.60	−3.50	+0.70
	RE	54	+33.60	+23.80	+25.55
14. AWM	RE	48	+9.80	−15.40	−3.85
	LE	41	−4.55	−5.60	+1.75
15. RBC	RE	41	+5.60	+7.00	+9.80
	LE	33	+3.50	−3.15	+2.80
16. JS	RE	49	−8.40	−16.10	−11.20
	LE	43	+11.20	+9.45	+12.25
17. HM	RE	43s	+7.35	+5.60	+15.05
	LE	32s	−2.10	−9.45	−2.80
	RE	45	+14.00	+7.00	+14.00
	LE	34	−1.05	−3.85	+6.65
	RE	41	+16.45	+8.40	+8.75
18. PW	RE	37	+2.10	−0.35	+1.75
	LE	54	+12.25	+4.55	+3.85
	RE	26	−15.40	−15.40	+3.50
	LE	44	+3.85	+1.75	+11.90
19. JAY	RE	43	+2.10	−4.55	+2.10
	LE	32	−5.60	−17.85	−10.85
20. WS	LE	48	+7.00	+9.80	+15.40
21. VF	RE	47s	−6.65	−6.65	+2.45
	LE	43	−20.65	−21.00	−15.05
22. BN	RE	40	−8.40	−15.40	−11.55
	LE	43	+9.80	−10.85	−7.70
23. SB	RE	41	−23.80	−23.80	−0.35
	LE	48	−10.85	−10.85	+4.55
	RE	40	−12.60	−12.60	—
	LE	44	−26.95	−26.95	+4.20
	RE	42	−22.40	−22.40	−3.50
24. HI	RE	51s	+11.90	+1.40	+4.90
25. PB	RE	43	+3.50	+4.90	+9.45
	LE	48	+2.45	+2.45	+14.00

Summary

Previously the relationship of the OSP to the IOP has been studied clinically; however, indirectly. The direct OSP has been well described in animals but its relationship to the IOP can only be superficially inferred. The purpose of this work is to study the relationship of the OSP to the IOP.

The OSP in control patients was compared with that of patients in whom the IOP was 41 mg. Hg. or more. The characteristics of the OSP in these two groups made it possible to distinguish between them. This implies a strong relationship between the OSP and the IOP. Features of the OSP demonstrated in patients with an IOP of 41 mm. Hg. or more if found in patients with an IOP of 40 mm. Hg. or less, probably indicates the presence of glaucoma.

Addendum

Summary of work to be published entitled: "Direct Clinical Ocular Steady Potentials: Role of The Corneal Epithelium Potential."

The Corneal Epithelium Potential has been well described in animals: on theoretical grounds the CEP would have to be accounted for in any discussion of the Ocular Steady Potential because one electrode is placed on the cornea. An outstanding clinical characteristic of the corneal epithelium is its vulnerability to trauma. By deliberately injuring the corneal epithelium with a calomel half-cell electrode on the one hand and protecting it from injury with a soft contact lens on the other, it is possible to delineate the role of the CEP in the OSP.

When the corneal epithelium is injured its potential is either partially or completely eliminated from the OSP. If the corneal epithelium is protected from damage by an electrode placed on its surface this potential alone is recorded and the OSP is not represented in the recording. In studying potentials from the globe where one electrode is placed on the cornea it is important to know if the corneal epithelium is damaged. Depending on this a CEP or OSP will be recorded.

Acknowledgment

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A list of references may be obtained by writing The Journal.

Reprint requests should be directed to A. J. Magee, M. D., 807 Atlas Building, Charleston, W. Va. 25301.

The Future Of Aphasia Therapeutics

Glen P. McCormick, Ph.D.

An increasing amount of attention is being paid to the long term needs of patients who have suffered language disturbances as a result of stroke or trauma. Such patients, generally referred to as *aphasics*, have characteristically received adequate medical care for their acute health needs, only to be released upon physical stabilization to face prolonged periods of social inadequacy and personal frustration.

While the medical and surgical care of stroke or trauma patients has improved steadily, it is distressing that the progress made to date in language rehabilitation has not paralleled the successes made in the medical area. It is perhaps more distressing, however, that the slower rate of progress in language therapy has led some persons to conclude that additional improvements in aphasia therapeutics will not be forthcoming.

Pessimism Toward Aphasia Rehabilitation

The pessimism which surrounds language rehabilitation for stroke and trauma patients speaks poorly for the communication extant between the disciplines involved, and one can parallel today's pessimism toward aphasia rehabilitation to yesteryear's pessimism with cancer patients. The horizons will not be elevated until all the health disciplines involved more objectively assess the attitudes, facilities and specialists engaged in aphasia therapeutics.

It is now clear to most aphasiologists that "aphasia" is a syndrome of communicative disorders relating to far more modalities than the traditional concepts of expressive and receptive speech. The language disturbances currently assessed within the framework of "aphasia" include: *gesture speech, reading, writing,* and *thinking* (inner speech), as well as *speaking* and *listening*. The schematic attempts to relate the modalities to the transmission channels are shown in Figure 1.

The Author:

- **Glen P. McCormick, Ph.D., formerly Associate Professor, Speech Pathology-Audiology, Department of Special Education, College of Human Resources and Education, West Virginia University, Morgantown; now at The Veterans Administration Hospital, Butler, Pennsylvania.**

Bedside diagnostics fail to properly identify the intact versus impaired modalities of language and are a poor excuse for detailed and properly administered tests for aphasia. While bedside screenings offer some information of value to physicians, the modern, formal aphasia batteries appear best for the long-term needs of the patients, and they provide important prognostic information as well. Until the language functions of the stroke and trauma populations are more adequately assessed, we will continue to fail in identifying those persons capable of responding positively to language therapy.

At present there is controversy as to the efficacy of language re-education with aphasics. The controversy appears to persist because of misinterpretations applied to existing literature, because of the relative absence of controlled studies with aphasic populations, and because of our utilization of assumptive rather than scientific evidence.

A good example of misinterpretation surrounds the report by Sarno, Silverman and Sands.[1] Sarno *et al* reported on a total of 31 patients who were subdivided into a programmed instruction, non-programmed instruction and an untreated control group. After a mean of 17.1 weeks of treatment it was concluded that there were no significant differences in outcome under the treatment conditions and that current speech therapy did not modify verbal behavior in the population studied.

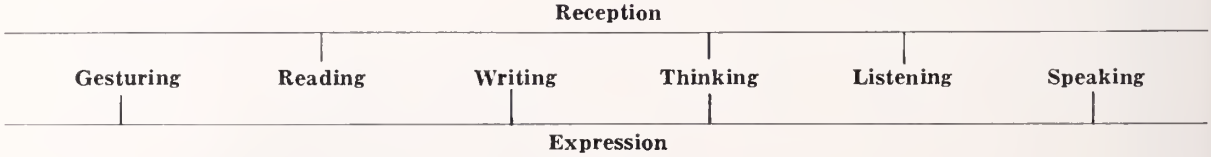

Figure 1

In a series of comments related to Sarno's article, others concluded, as reported by Darley,[2] that Sarno's findings would not endear the author to fellow speech pathologists but would confirm the long standing contentions of many physicians, namely that speech therapy with aphasics was generally regarded as uneventful as far as improvement was concerned.

Obviously, Sarno's conclusions were subjected to a process of over-generalization, since the work was related from the beginning to *severe* aphasics and was not intended to pertain to less involved patients receiving any other kind of treatment.

Review of Studies on Aphasia

Smith *et al*,[3] in a comprehensive report supported by a Social and Rehabilitation Services grant, reviewed a series of modern studies on aphasia which indicated that significant improvement had indeed resulted from language therapy when controls were applied to both the patients and the therapy techniques. Smith, however, lamented at the number of researchers who attempted to reach conclusions on the effectiveness of therapy with patients who were poorly screened for inclusion in the studies, and for conclusions which were reached after abysmally short periods of actual therapy time — some for fewer than 10 clock hours (3; p. 93).

Negative or suspicious attitudes as to the effectiveness of other than speech therapy with stroke patients is also in evidence, witness the comments made about the value of physical therapy by Browne and Poskanzer,[4] who indicated that:

> . . . It has not yet been demonstrated that patients receiving formal physical therapy after strokes recover more quickly or more completely than those who receive no therapy. Where studies have been carried out, a judgement has been required by the authors about whether or not the patient has been improved; such judgement obviously is open to observer bias (4; p. 599) . . .

Browne and Poskanzer developed their line of reasoning to a slightly greater degree later in their article but cited only two studies which supported their contention as to the apparent ineffectiveness of formal versus informal, functionally-oriented medical care. The goals set in therapy were not stated for the research evaluated and this writer takes exception to the manner in which Browne and Poskanzer reached their conclusions, feeling certain that solid decisions cannot be objectively reached on such a small sample of research, and feeling too that physical therapists all across the nation could challenge such findings.

Controlled Studies Needed

It would appear that now is the time for all persons engaged in stroke patient care to undertake carefully controlled studies which measure the effectiveness of treatment against clearly stated research hypothesis. The period of "eyeballing" progress should have passed, leading us to studies which categorize stroke and trauma patients according to such variables as: age, sex, education, measured levels of motivation, etiology, *actual* time in therapy, sophistication of therapists, techniques applied, etc. In short, until some kind of controls are applied to aphasiology as are applied to Petri dishes, drug research, etc., all knowledge obtained will be open to suspicion.

In 1969, the Department of Health, Education and Welfare published a report prepared by The Subcommittee on Human Communication and Its Disorders[5] which stipulated that in the United States there were approximately 2,000,000 persons who had survived strokes, estimating further that 400,000 of these persons could be expected to be aphasic. By adding to this figure the 200,000 trauma-related aphasics and 1,500,000 children with neurologically based central language dysfunctions, it seems fair to place the nation's total of central communicative disorders at the impressive figure of 2,100,000 (5; p. 16).

Given the figures provided by the above-cited subcommittee, our country seems to have devoted very little attention to facilities which could offer longitudinal care for language rehabilitation with aphasics. This issue bears attention at high levels, especially when one understands that language therapy does not ordinarily demand large amounts of space or inventories of expensive equipment.

Few Hospitals Equipped for Treatment

Currently, military, Veterans Administration, and a select few private hospitals and treatment centers appear devoted to the comprehensive needs of aphasics and are administratively equipped to bear the expenses of laborious, repetitive types of treatment. In those centers, however, where aphasia specialists are engaged in intensive aphasia therapy impressive results are being reported which lend optimism to the future of aphasia therapeutics.

The attention of aphasia therapists is not centered on the severe aphasic, or on those whose age and medical condition is against them. The

current emphasis is appropriately placed on those language-disturbed persons who are young enough and healthy enough to overcome that part of their communicative defect which is correctable. With the successes currently being realized by selected patients, there is every reason to believe that new horizons have been reached in aphasia therapy.

The degree of improvement in therapy techniques and the speed with which the improvement will occur will be influenced across our country by the attitudes, facilities and specialists operating at the local level. Until each medical region can boast of an aphasia therapy center and staff, we will continue to "waste" those stroke and trauma patients who have potential for language recovery.

If cancer care has progressed as it has "against the odds," perhaps the forthcoming generation of aphasiologists can progress in kind with aphasia therapy; however, until a new era of optimism breeds new diagnostic and therapy centers, additional years of pessimism will stall progress for aphasics.

A list of references may be obtained by writing The Journal.

Manuscript Information

Manuscripts to be presented for publication in *The West Virginia Medical Journal* should be typewritten, triple-spaced, on one side only of firm (not onion skin or flimsy), standard letter sized (8 1/2 by 11 in.) white paper. Wide margins (at least 1 1/4 in. on left) should be left free of typing. On the first or title page should be shown the title of the article, the name (or names) of the author, and his degrees. Pages should be numbered consecutively, the page number being shown in the right upper corner along with the surname of the author.

Authors are requested to submit a carbon copy with the original or retain same in the event the manuscript is lost in transmittal.

Illustrations should be numbered and their approximate locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for cuts should be done in black (India) ink on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it. The author will bear the cost of all over two one-column halftone cuts.

All scientific material appearing in *The Journal* is reviewed by the Editorial Board. Manuscripts should be mailed to The Editor, West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

A Token Economy On A Geographic Psychiatric Ward

William J. Wyatt, M. S.

In recent years the use of token reinforcement programs in treating chronic psychiatric patients has been on the increase. At Huntington State Hospital an experimental token economy program was established on a geographic ward. The Geographic Unit System necessarily renders impractical some treatment methods while serving as a suitable ground for others. A major advantage of the token economy is that it lends itself to the wide variety of functional diagnoses and intellectual levels found within the geographic ward.

Additional advantages in the use of generalized conditioned reinforcers which have been pointed out by Kazdin and Bootzin (1972) include: (1) tokens bridge the delay between target response and back-up reinforcement; (2) tokens permit reinforcement of a response at any time; and (3) provide the same reinforcement for individuals who have different preferences. Ayllon and Azrin (1968) listed several other advantages of using token reinforcement: (4) the number of tokens can bear a simple quantitative relationship to the amount of reinforcement; (5) being portable, the tokens can remain in the individual's possession; (6) any number of tokens can be earned; and (7) token operated machines can be used to dispense reinforcement.

A number of token reinforcement program descriptions are available including those of Ayllon and Azrin (1965), Winkler (1970), Atthowe and Krasner (1968), Wince, Leitenberg and Agras (1972), Schaeffer and Martin (1969), McConahey (1972), and Lent (1968).

Method

Subjects—Thirty-four male patients on Ward Six at Huntington State Hospital participated in the program. The patients ranged in age from 12 to 68 years at the start of the program in September, 1973. The average age was 41.5 years. Most patients were long-term residents of the hospital—the average length of previous hospitalization being 14 years, while the length of prior hospitalization covered a range of one month to 35 years.

As was expected within the Geographic Unit System, a variety of diagnoses characterized the 34 patients. The diagnoses and number of patients so diagnosed are presented below:

Severe mental retardation—7.

Schizophrenia, chronic undifferentiated type—6.

Moderate mental retardation—5.

Non-psychotic organic brain syndrome—3.

Moderate mental retardation with psychosis—2.

Paranoid schizophrenia—2.

Adjustment reaction to adolescence—2.

Severe mental retardation with psychosis—1.

Mild mental retardation with non-psychotic OBS—1.

Moderate mental retardation with CBS—1.

Schizophrenia, simple type—1.

Schizophrenia, schizo-affective type—1.

Reactive depression—1.

Alcoholism—1.

Total—34.

Three of the 34 were discharged prior to the end of the study. A few newly admitted short-term patients also participated in the program. Their presence probably did not confound the results of the study as their ranks were kept at a relatively constant number.

Procedure

Behaviors generally considered necessary for satisfactory placement and maintenance of the patient outside the hospital were specified as target behaviors. These included the elements of basic personal hygiene (brushing teeth, shaving, bathing, changing clothes, etc.) and performance of useful activity. Various forms of useful activity were available to the patients including attending assignments in remedial education, special education, the hospital greenhouse, occupational therapy and recreation. Other specified useful activity consisted of ward work such as sweeping, mopping, dusting, making beds, carrying out trash, gathering laundry

The Author:

- **William J. Wyatt, M. S., Staff Psychologist, Huntington State Hospital.**

and helping care for severely and profoundly mentally retarded patients. Baseline data on the target behaviors was recorded prior to the start of the token program.

An area on the ward was designated as the "ward store" and stocked with cigarettes, candy, coffee, transistor radios, clothing and toiletry items. The cost in tokens of each item in the ward store was decided upon as was the number of tokens paid for each target behavior performed.

The staff conducting the program consisted of the existing ward staff. No additional staff was added to the ward for purposes of carrying out the program.

Following the base-line observation period the actual token program began. The first four weeks, however, consisted of an acquisition period during which patients were acquainted with the general framework of the program. Because many patients were rather severely regressed or retarded, a step-by-step program was undertaken to educate the patients concerning basic program considerations:

Week One

After a brief explanation of the program, each patient was given one token (poker chips served very adequately as tokens) and advised to keep the token so that he could buy something with it. Thirty seconds later the patient was allowed to buy an item from the ward store, thereby reinforcing the concept of "value" of the token. This procedure was repeated three times each day during the first week.

Week Two

As in the first week, each patient was given one token. The patient, however, was required to hold the token for 90 minutes before buying an item, thus familiarizing patients with the "open" and "closed" hours of the ward store.

Week Three

In order for patients to learn that they would be able to possess more than one token at any given time, two tokens were given to each patient. After two hours the ward store opened and patients purchased two items. Throughout the third week this procedure was carried out twice each day.

Week Four

Patients were first given one token each. After an hour another token was given to the patient. Both tokens were spent in the ward store at the end of two hours. The sequence was carried out twice per day. The procedure of the fourth week was designed to make patients aware that tokens were available at various times.

Fifth Week

Beginning with the fifth week patients received tokens only on performance of target behavior. Social reinforcement in the form of praise accompanied token reinforcement. Patients received tokens immediately after performing the desired behavior and the ward store opened twice each day for 30-minute intervals. Ward staff kept daily records on the total number of tokens spent as an indirect, although telling, record of the general increase in the level of adaptive behavior exhibited by the patients.

Results

Over a six-month period the steady increase in the number of adaptive behaviors being exhibited was evidenced by the increase in token spending. During the base-line period patients were observed and behaviors which were later made token contingent were recorded. It was found that during the base-line period the group of 34 patients exhibited enough target behavior to have been earning and spending tokens at a rate of 48.5 per day.

When the receipt of tokens was made contingent on performance of target behavior (November) the patients' adaptive behavior began to increase. During that first month patients spent an average of 97.6 tokens per day. The average number of tokens spent per day during the succeeding months is presented below.

Month	Average Daily Token Spending	Percent Increase Over Baseline
September	48.5 (base-line)	—
October	Acquisition period	—
November	97.6	101%
December	128.4	164%
January	153.2	215%
February	183.8	279%
March	141.0	190%
April	205.5	323%

Subsequent months showed steady increases in target behaviors exhibited leading to a 323 per cent increase in spending during the sixth month (April). During only one month (March) did token spending and adaptive behavior decrease. This was traceable directly to the temporary suspension of program funding

and resulting scarcity of items for the ward store.

Discussion

Ward Staff was encouraged to participate in planning of the program. At the end of six months covered by the study, a number of procedural changes were enacted by the staff, to the betterment of the program. Changes included allowing for a modest rate of inflation of costs of ward store items, institution of a system of fines to be exacted as penalties for tantrum and other maladaptive behavior, and the presentation of a wider variety of goods and services which patients were able to buy with tokens.

An additional observed advantage of the token system was the apparent ease with which new patients became involved. Usually within two to three days after being admitted to the ward the newly hospitalized patient was found to be earning tokens and, thus, improving his behavior.

A major difficulty was reached during the fifth month when, as a result of insufficient funding, ward store supplies were no longer available. It was no surprise that token earning and spending declined and with them the general level of adaptive behavior exhibited by the patients also declined. After additional funding became available, the ward store was restocked, and the level of adaptive behavior reached new heights.

Summary

Thirty-four male patients on a geographic ward at Huntington State Hospital were involved in a token economy program. The patients' daily token spending rates served as the dependent variable. An increase of 323 per cent in the number of target behaviors exhibited was noted over a six-month period. Two primary advantages of the token system are its applicability to the geographic unit where patients with a variety of diagnoses are found, and the ease with which the new patient becomes involved.

Acknowledgment

The author wishes to thank the following Psychiatric Aides who carried out the program: Norman Adkins, Phillip Booth, Eleanor Carter, Carol Edwards, Dorothy Houston, Estella Stevens and Alvis Watts.

A list of references may be obtained by writing The Journal.

AMA Publication Honors Doctor Bean

William Bennett Bean, M.D., noted medical scientist, philosopher, teacher, editor and writer, was honored in a special issue of *Archives of Internal Medicine,* a scientific publication of the American Medical Association.

The November issue of the *Archives* was a "Festschrift" to Doctor Bean, who is Director of the Institute for the Humanities in Medicine of the University of Texas Medical School at Galveston. Festschrift means a group of articles published as a memorial tribute to a scholar. The issue contains a number of articles about Doctor Bean written by his colleagues. It also republishes several articles by Doctor Bean himself.

Doctor Bean studied medicine at the University of Virginia and taught there for several years. After advanced training in Baltimore and Boston, he was at the University of Cincinnati College of Medicine for a number of years.

In 1948, Doctor Bean became Professor of Medicine and Head of the Department of Internal Medicine at the University of Iowa College of Medicine and Physician-in-Chief at University Hospital, Iowa City. He remained at Iowa until accepting the Galveston appointment last year.

A message from . . .

The President

FOLLOW THE STAR

A bit less than 2,000 years ago, a spirit for the quality of life came over the civilized world in the person of Jesus Christ. Other religions of the world have experienced a similar announcement before and after the birth of The Messiah. The underlying themes for all has been the exposure and improvement in the quality of life for mankind.

Waves of spirituality and decadence have alternately washed over the world since that day. Anybody with enough years to have graduated from medical school has experienced some of both!

Among others in Medicine, Hippocrates, Maimonides and Sir William Osler have brought fresh breath and substance to our profession. Since the early 20th century, a virtual parade of physicians, surgeons and allied scientists have given their professional lives to improving the quality of medical care; indeed, the quality of *life*. More than in any other profession, there is just cause to be proud of our heritage.

Lest we lose our balance, however, as Men and Women of Medicine we also are citizens of the world. In this high responsibility, shared with all humankind, we have not achieved nearly so well. Many of the ills of the world inaccurately have been laid on Medicine's threshold. Infant mortality, poor housing, poverty, malnutrition, ignorance and ethnic differences are *Social* ills—not products of poor-quality medical care.

As citizens of the world, as brothers, wouldn't it be appropriate in this Christmas Season, in the Christmas Spirit, to reflect upon the past, to assemble our skills of the moment, and project ourelves in a solid wave to again improve the *quality of life*.

Merry Christmas and Happy New Year to All!

Bill Gilmore

William E. Gilmore, M. D., *President*

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Editor
GEORGE F. EVANS, M. D.
122 South Sixth St.
Clarksburg, W. Va.

Managing Editor and
Business Manager
MR. WILLIAM H. LIVELY
Box 1031
Charleston, W. Va. 25324

Associate Editors:
VERNON E. DUCKWALL, M. D.
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EDITORIALS

CARL BEMIS HALL

How can you honor a man that has through his own accomplishments brought so much honor to his fellow physicians, his medical organizations and to his State? Those of us who have had the privilege of knowing Carl Hall for many years are aware of his tremendous capacity for work and his enduring dedication to furthering the causes of organized medicine and the primary needs of our patients.

Doctor Hall was one of the original organizers of the West Virginia Chapter of the American Academy of General Practice. He helped formulate their Constitution and By-Laws, and acted as their Secretary for many years. Carl continued to serve in many capacities, and his drive and interest never faltered.

After serving as President of the West Virginia Chapter, Carl went on to serve in the national organization. As a member of their Congress of Delegates for over 10 years, he was called on to assume greater responsibility as chairman of various reference committees and as chairman of several important standing committees.

Finally in 1971, Doctor Hall won election to the Board of Directors of the American Academy of Family Physicians. This position became a greater opportunity for service, which culminated in his election to the Chairman of the Board of Directors in 1973.

All of these events were but a prologue to the high honor that was accorded Doctor Hall when in Los Angeles on October 14, 1974, he was elected to the high office of President Elect of the American Academy of Family Physicians.

Carl B. Hall, M. D.

Next year at their annual meeting in Chicago, Dr. Carl B. Hall will be installed as President. The summit will have been reached, but from this point of view new horizons of service will become evident to this man of vision. He deserves all the honor, and in his accomplishments he has brought honor to all those who have had the pleasure of knowing him and working along side of him.

I am sure that somewhere along this road there were times of discouragement and disappointment, but in Doctor Hall's mind there were goals to be reached and programs to be implemented. His high ideals and drive kept him going and his dedication did not waver. As we follow his progress in the future, we can anticipate his goals will never be entirely satisfied, but he will always be reaching out to find new ways and means to expand the role of the Family Physician in the total health care of the patient and his family.

We wish him well and congratulate him on his accomplishments.—*Seigle W. Parks, M. D.*

Many words of commendation have been written and published in *The Journal* about Dr. Carl B. Hall—especially in recent years while he has gone through the chairs to reach the top in the official ranks of the American Academy of Family Physicians.

We believe, therefore, it would be difficult to attempt to add to the above editorial written for *The Journal* by one of his closest personal friends and colleagues, Dr. Seigle W. Parks.

We simply will furnish the following brief biographical information concerning this cordial and wonderful physician and gentleman so the record will be complete when younger men and women refer back to bound issues of *The Journal* for historical purposes:

Doctor Hall was born in Williamson and was graduated from West Virginia University. He received his M.D. degree in 1940 from the Medical College of Virginia and interned at Charity Hospital of Louisiana in New Orleans, 1940-41.

He served as a Major in the Medical Corps of the United States Army during World War II and has been in the active practice of medicine in Charleston since 1946. He immediately became active in the affairs of organized medicine and has participated in many activities of the Kanawha Medical Society and the West Virginia State Medical Association. He served as President of the county society in 1959 and has been a member of many key committees of the State Medical Association. He served as Chairman of the Association's Program Committee in 1966 and several of his scientific papers have been published in *The Journal.*

A charter member of the West Virginia Chapter of the AAFP, Doctor Hall served as the organization's first Secretary-Treasurer and for a number of years has been Editor of the Chapter's publication, "Mister Doc."

On the national level he first was elected a Delegate to the AAFP in 1960 and in subsequent years was named to serve as Chairman of that organization's Insurance Committee and the Committee on Legislation and Public Policy. This dedicated involvement led to his election to a three-year term as a member of the Board of Directors of the AAFP in 1971 and he was named Chairman of the Board at the conclusion of the Annual Meeting in October, 1973.

Fortunately, Doctor Hall's many friends throughout the State and country convinced him to run for President Elect of the AAFP during the Annual Meeting in Los Angeles in October this year. His victory against a highly qualified opponent speaks well for the ability of Doctor Hall and we know he will be a decided asset as spokesman for the AAFP during the next few years. We feel sure Doctor Hall realizes he can always turn to his many friends whenever he needs assistance in helping to lead the national organization composed of more than 35,000 family physicians.

THANATOLOGY?

Abortionist has never been a term of approbation. It has always carried with it the image of a sleazy person carrying out a bloody, clandestine act for purposes of sordid venality. The picture is changing. We now have college professors in Brooks Brothers suits giving papers at prestigious medical meetings describing methods and statistics from their pregnancy termination programs, which are dedicated to the most humanitarian ideals.

As a result of the new image among abortionists, an impression is somehow developing that the profession of medicine has given its unqualified approval to abortion as a medical procedure to correct the unfortunate consequences of indiscreet passion. Nothing could be further from the truth. Controversy burns intensely within the profession on this subject.

Opponents of liberal abortion have not been as noisy as proponents. The relative silence of opponents has resulted partly from shame and

an unwillingness to point up the fact that they are professionally identified with people they would as soon condemn, just as they might not want to broadcast it about that their cousin has just been caught robbing a bank. Partly too, they have been intimidated into silence by the academic credentials of the new abortionists and their social-sexual revolutionary supporters. It is only in hospital dressing rooms and cafeterias, at medical society meetings or quiet gatherings of doctors that the depth of the controversy can be appreciated.

It is just not easy for doctors who have dedicated their lives to saving and preserving life to become executioners. It can be said without fear of contradiction that there is a unanimity of opinion that in an abortion life is destroyed.

The legalisms cited by abortionists in defense of charges of destroying life are woefully weak and shamefully unscientific—as well as medically pointless. The fact that the Law does not legally establish nor effectively protect the rights of the unborn is meaningless from a biological standpoint. That the government will not issue a social security number nor are life insurance policies issued on the unborn are facts which would be laughable were they not so pathetically inappropriate to the real issue of the presence or absence of life in a fetus.

Abortion is not a moral problem for doctors. Problems of sin can be left to the preachers and theologians. Most doctors have a difficult enough time dealing with problems of the mortal body without volunteering to deal with the problems of a patient's immortal soul. The problem is simply that if we lose reverence for life, we will be unworthy of and will quickly lose the respect and trust of our patients. This is a serious problem for the entire profession.

The medical profession is being asked to endorse, at least tacitly, the turning of a corner the direction of which is away from the preservation of life. When such an endorsement is forthcoming, our patients will have good reason to be apprehensive about the imminence of euthanasia for the chronically sick, the halt and the lame, the weak and the feeble and the unproductive. That solution to these other social problems is certainly on the horizon in the direction of the proposed new compass heading. Will we then need a new specialty—the specialty of life termination?

Proponents of liberal abortion within the profession are not necessarily venal. They can be honest and sincere in their humanitarian rationalizations. The profession of medicine, however, cannot allow them to speak for it. We are duty bound, at the very least, to acknowledge the existing controversy.

Sugarplums 1974

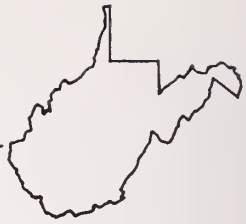
A Christmas tree. A table set.
An oil rig. A minaret.
Noel, Noel. Praise Allah too.
Mohammed grins Good Will to you.

A crowded shop. A tiny gift.
A desert waste. Sand dunes adrift.
Three Eastern Kings enraged because
Muezzin choirs sing Glorias.

A Midnight Mass. An airplane crash.
Curved scimitars. A tiny creche.
Sweet Babe, God's Son, Thy will be done.
Forgive me my delirium.

Stephen D. Ward, M. D.

GENERAL NEWS



Clinical Conference Announces Four Additional Speakers

Plans are nearing completion for the Eighth Mid-Winter Clinical Conference to be held in Charleston next January 24-26 at the Daniel Boone Hotel.

The program will include 15 scientific speakers, beginning at 2 p. m. on Friday, January 24, and concluding at noon on Sunday, January 26. In addition to the scheduled speakers, there will be a Cardiopulmonary Resuscitation demonstration Friday afternoon and all day on Saturday. With emphasis on lay education, the demonstration will be sponsored by the Cardiopulmonary Resuscitation Committee of the American Heart Association, West Virginia Affiliate.

The Conference will begin with opening remarks by Dr. Hartwell G. Thompson, Dean of the Charleston Division, West Virginia University Medical Center.

Conference Faculty Completed

The faculty for the Conference has been completed with the acceptance of speaking invitations by four physicians—Drs. Stafford G. Warren and William H. Carter, Charleston cardiologists; Dr. Paul Travis of the Washington, D. C. area; and Dr. Raymond H. Bunshaw of Atlanta.

H. G. Thompson, M.D.

Richard S. Crampton, M.D.

Doctor Warren will be the first speaker at the Friday afternoon session on the topic of "The Use and Abuse of Cardiac Drugs." Doctor Carter also will speak at the Friday afternoon session on "Pre-Hospital Coronary Care in West Virginia." Doctor Travis will discuss "Drugs and Alcoholism Among Teenagers" at the public session Friday evening and the medically-oriented session Saturday morning on "The Problems of Adolescents." Doctor Travis is Director of the D. C. Department of Human Resources Rehabilitation Center for Alcoholics at Occoquan, Virginia.

Doctor Bunshaw, who is Southern Area Vice President for Medical Affairs, American Cancer Society, will speak at the Sunday morning session. His topic will be "Cancer Rehabilitation and the American Cancer Society."

Presiding Physicians Announced

The Conference Co-Chairmen, Drs. Ralph H. Nestmann and Joseph T. Skaggs of Charleston, also have announced the physicians who will preside at the Conference sessions. They are:

Drs. John W. Traubert, Chairman, Department of Family Practice, WVU School of Medicine, Friday afternoon; Harry S. Weeks, Jr., Wheeling, President of the West Virginia Medical Institute, Inc., Friday evening session on "PSRO Revisited One Year Later;" Herbert H. Pomerance, Director of Pediatrics, Charleston Area Medical Center; and Professor of Pediatrics, Charleston Division, WVU, Friday evening public session on "The Problems of Adolescents;"

W. Gene Klingberg, Professor and Chairman, Department of Pediatrics, WVU, medically-oriented session on "The Problems of Adolescents" Saturday morning; Hartwell G. Thompson, Saturday afternoon; and Robert C. Parlett, Vice President of Health Sciences and Dean of the medical school at Marshall University, Sunday morning.

Attendance at the Conference will be acceptable for 12 hours of Category 1 credit toward the Physician's Recognition Award of the American Medical Association; the Conference also has been approved for 12 hours of Prescribed Credit by the American Academy of Family Physicians.

Other Conference Topics

Speakers and their topics previously announced are:

"Cardiac Emergencies in Children"—Nancy Wanderman, M. D., Assistant Professor of Pediatrics, Pediatric Cardiology, Charleston Division, WVU; and "Mobile Coronary Care Unit"—Richard S. Crampton, M. D., Associate Professor of Medicine and Director, Coronary Care System, University of Virginia (Friday afternoon);

"PSRO Revisited One Year Later"—James C.

Respess, M. D., Department of Internal Medicine, University of Virginia School of Medicine; and William C. Felch, M. D., Rye, New York (Friday evening);

"Human Sexuality and Youth, A Timely Challenge"—U. G. Turner, III, M. D., Assistant Professor, Department of Obstetrics and Gynecology, University of Virginia School of Medicine; and "Teenage Suicides"—Ralph S. Smith, Jr., M. D. Charleston psychiatrist (Friday evening concurrent public session);

Robert C. Parlett, M.D.

Stanley E. Preiser

"The Diagnosis and Medical Management of Cerebral Vascular Disease"—Arthur L. Poffenbarger, M. D., Charleston neurologist; "The Surgical Management of Cerebral Vascular Disease"—G. Robert Nugent, M. D., Professor and Chairman, Division of Neurosurgery, WVU; and "Vascular Changes in Diabetes Mellitus"—Harvey C. Knowles, Jr., M. D., Professor of Medicine, University of Cincinnati College of Medicine;

"Pulmonary Disease in Adolescents"—C. E. Buckley, III, M. D., Associate Professor of Medicine, Assistant Professor of Immunology, Departments of Medicine and Microbiology-Immunology, Duke University Medical Center; and "How To Avoid Malpractice Suits"—Stanley E. Preiser, Charleston attorney.

Other Groups Meeting During Conference

Meeting Friday evening at 7:30 at the Charleston National Plaza auditorium will be the American Diabetes Association, West Virginia Affiliate, at which Dr. Harvey C. Knowles, Jr. will be the speaker. Other groups meeting at the headquarters hotel in conjunction with the Conference will be the Section on Orthopedic Surgery of the State Medical Association, the Board of Directors of the American Diabetes Association, West Virginia Affiliate; and the West Virginia Thoracic Society (Annual Meeting), all at noon on Saturday. There will be a breakfast meeting of the West Virginia Chapter, American Society of Internal Medicine, on Sunday morning.

A fee of $15 for the entire Conference will be charged all registrants except nurses, medical students, interns and residents.

The annual Mid-Winter Clinical Conference is sponsored by the State Medical Association in conjunction with some of its component medical groups, and volunteer health organizations.

The complete program and final details will be provided in the January issue of *The Journal.*

Kanawha Medical Society Offers Social Event

Physicians, wives and others attending the Mid-Winter Clinical Conference are invited to the annual dinner dance of the Kanawha Medical Society which will be held Saturday, January 25, in the Daniel Boone Hotel ballroom beginning at 7 P. M. The affair will include cocktails, dinner and dancing. Dress will be formal.

The cost will be $12.50 per person. Advance registration is requested. Registrations and advance payment, if desired, should be sent to the Kanawha Medical Society, 405 Atlas Building, Charleston 25301. Payment also may be made at the door. Checks should be made payable to the Kanawha Medical Society.

All registrations should be in by January 21.

January 1 Deadline For Heart Post-Doctoral Fellowship

January 1, 1975, is the deadline for applying for a Post-Doctoral Research Fellowship in cardiovascular diseases and related basic sciences sponsored by the American Heart Association, West Virginia Affiliate.

The Heart Association also announced it is accepting applications for grants-in-aid for research in the field of cardiovascular disease. The deadline for these applications is March 1, 1975.

The recipient of the Post-Doctoral Research Fellowship is required to devote 100 per cent of his time to his research. He must be under the direct sponsorship of a mature investigator in the cardiovascular field or in basic sciences related to it.

Candidates must hold an M. D., Ph.D., or equivalent domestic or foreign degree. The stipend will range from $8,000 to $12,000, depending upon qualifications and experience. Matching funds may be competitively applied for from the AHA to bring the total stipend to a maximum of $16,000. The duration of the award will be for one year, beginning as early as January 15, 1975.

The heart research grants-in-aid are not restricted to any particular discipline, although the investigator must be an M. D., Ph.D. or equivalent

qualified and have available facilities necessary to pursue the investigation.

Individual requests for grants should not exceed $4,000. Awards will be based on merit, need and available funds.

The candidate must submit an official application for either award. Additional information and application blanks for both awards may be obtained by writing either: Charles Sikorski, Executive Director, American Heart Association, West Virginia Affiliate, 211 Thirty-Fifth Street, S. E., Charleston 25304; or Allen F. Bowyer, M. D., Chairman, AHA-WVHA Research Committee, WVU Medical Center, Morgantown 26506.

Ophthalmology Association Elects Drs. Ryan and Esposito

Dr. Ralph W. Ryan of Morgantown was installed as President of the American Association of Ophthalmology at the conclusion of that organization's annual meeting which was held in Dallas, Texas, October 5-10.

Another West Virginia physician, Dr. Albert C. Esposito of Huntington, was named President Elect and will succeed Doctor Ryan at the next annual meeting.

Ralph W. Ryan, M. D.

Doctor Ryan, who has practiced his specialty of ophthalmology in Morgantown since 1955, succeeded Dr. Charles E. Jaeckle of Defiance, Ohio.

Doctor Ryan was graduated from West Virginia University and received his M.D. degree from the University of Michigan School of Medicine. He also received an M.S. degree in ophthalmology from the same institution in 1953. He interned at St. Joseph's Mercy Hospital and served a residency at the Wayne County General Hospital. Prior to locating his practice in Morgantown, he was involved in research with the United States Public Health Service at the Clinical Center of the National Institutes of Health.

Doctor Esposito, who has practiced in Huntington since 1946, is a Past President of the West Virginia State Medical Association and the Southern Medical Association. A more complete biographical sketch on Doctor Esposito may be found elsewhere in this issue of *The Journal* in an article concerning his selection as recipient of the 1974 "Stritch Medal" award at a ceremony which was to be held in Chicago on November 19.

Dr. Esposito Receives High Honor From Loyola University

Dr. Albert C. Esposito of Huntington was selected by the Board of Trustees of Loyola University in Chicago as the recipient of the 1974 "Stritch Medal" award which is named after the late Cardinal Stritch of Chicago.

Doctor Esposito was scheduled to receive the Medal at the annual award dinner at the Conrad Hilton Hotel in Chicago on November 19.

Albert C. Esposito, M. D.

The award is given each year to an outstanding American who has distinguished himself in a special field of endeavor. In the field of ophthalmology, the Board of Trustees announced that the only other award of the Stritch Medal was made five years ago to Dr. Frank W. Newell, Professor of Ophthalmology at the University of Chicago and President Elect of the American Academy of Ophthalmology and Otolaryngology. Doctor Esposito and Doctor Newell were classmates while students in medical school.

In a letter to Doctor Esposito announcing the award, the Chancellor of Loyola University, Father James F. Maguire, S. J., noted that the committee had chosen Doctor Esposito because of "your years of dedicated service to your profession, your specialty and your community, and acceptance of this honor will allow us to acknowledge your efforts in behalf of the profession of medicine."

A native of Pittsburgh, Pennsylvania, Doctor

Esposito was graduated from the University of Pittsburgh and received his M.D. degree cum laude in 1938 from the Stritch School of Medicine of Loyola University. He served his internship at the University of Pittsburgh Teaching Hospital and St. Francis Hospital, 1938-39, and a residency in ophthalmology at the Ohio State University College of Medicine, 1940-41. He was an Instructor in the Department of Ophthalmology at the Ohio State University College of Medicine, 1944-47.

He was certified by the American Board of Ophthalmology in 1950 and that same year he was elected a Fellow of the American Academy of Ophthalmology and Otolaryngology.

During World War II, Doctor Esposito served in the Medical Corps of the United States Army and was released with the rank of Major.

Doctor Esposito immediately became active in organized medicine when he located his practice in Huntington and served terms as President of the Cabell County Medical Society, West Virginia Academy of Ophthalmology and Otolaryngology, and the West Virginia State Medical Association. He also served as President of the Southern Medical Association, 1970-71.

Recently, Doctor Esposito has been one of the prime movers in the effort to establish a medical school at Marshall University.

His most recent achievement was his successful candidacy for a seat in the West Virginia House of Delegates from Cabell County.

Institute Renames Officers, Sets Sights on Challenges Ahead

The West Virginia Medical Institute's Board of Trustees has reelected its President, Harry S. Weeks, Jr., M.D., of Wheeling, and its other officers to serve until early 1976; and has set its sights on growing educational and other challenges ahead.

The non-profit, non-stock Institute, with membership open on a voluntary, dues-free basis to all doctors of medicine and osteopathy licensed and practicing in the state, had 847 members as of November 1. That figure represented 47 per cent of the physicians holding permanent, unrestricted licenses in West Virginia.

At an October 27 annual membership meeting, discussion centered about a number of key topics—including how professional standards review might be implemented in the state; general educational objectives, and a new medical consultant agreement under which the Institute provides professional review and other services to Southern West Virginia Blue Plans.

Completed prior to the October meeting, under Board of Trustees direction, was a 113-page draft of a professional standards review plan for West Virginia—a draft which, at this writing, was undergoing detailed review by the U. S. Department of Health, Education and Welfare.

Still uncertain—in the light of complex funding and guideline-development problems faced by HEW—was when, and in what particular form, further implementation of professional review might be brought about.

The Institute decided, however, to provide a summary of key components of its plan draft to all its physician members with its October information bulletin; and that summary also is offered with this article in an effort to obtain even broader understanding of it.

As of early November, Institute officers emphasized, the plan was in *draft* form, with some revisions certain before final approval of it by HEW, perhaps by the end of 1974. The Institute leadership stressed it would appreciate any reaction, comments, etc., with regard to the draft.

Other officers reelected by the Institute Trustees were Oscar J. Bailes, D.O., Princeton, Vice President; J. L. Mangus, M.D., Charleston, Secretary, and Robert R. Weiler, M.D., Wheeling, Treasurer.

The Board of Trustees session followed immediately the October 27 membership meeting at which Worthy W. McKinney, M.D., and Richard G. Starr, M.D., both of Beckley; David Z. Morgan, M.D., of Morgantown, and Joseph T. Skaggs, M.D., Charleston, were elected to three-year terms as Trustees.

Holdover Trustees include Doctors Weeks, Bailes, Mangus and Weiler; George R. Callender, Jr., M.D., Charleston; Winfield C. John, M.D., Huntington; William E. Gilmore, M. D., Parkersburg, and Philip M. Sprinkle, M.D., Morgantown.

In other action at its meeting, the Institute membership:

—Voted to hold its next meeting in conjunction with the January, 1976, Mid-Winter Clinical Conference, probably to be held in Charleston.

—Heard the Institute staff report completion of a medical care evaluation study process—a major component of pending professional standards review activity—and hopes to have a pilot study underway in November in cooperation with a 52-bed hospital.

—Reviewed other staff plans to make initial contacts with hospitals in November toward offering funds available to the Institute to help those hospitals now without such systems to obtain—if they desire—clinical information or medical records systems (PAS-MAP or HUP).

In a preface to its summary of the draft of the proposed professional standards review organization (PSRO) plan for West Virginia, the Institute emphasized several points.

—The draft is designed to permit maximum flexibility in implementing any review structure in close harmony with patterns of medical practice as they exist in different parts of the state. It also recognizes current activity toward medical

audit and related systems at many hospitals, with provisions for delegation of review authority to hospital medical staffs when they demonstrate capability to handle such responsibilities.

—Major emphasis has been placed on interrelationships between professional review activity and continuing medical education.

—While initial PSRO activity will center about hospitalized Medicare, Medicaid and Maternal and Child Health Program cases, the plan will permit development of a uniform, all-patient review system as recommended by the West Virginia State Medical Association.

Here is the summary of the draft of the proposed State PSRO Plan:

PROPOSED PSRO PLAN FOR WEST VIRGINIA; Summary of a Draft Document

The Overall Picture

Until January 1, 1976, (under terms of present statute) the Secretary of the U. S. Department of Health, Education and Welfare can enter into contracts ONLY with organizations of physicians to implement the Professional Standards Review Organization (PSRO) law. West Virginia has been designated by the Secretary as a single PSRO area; and the West Virginia Medical Institute, Inc., as a free-standing non-profit, non-stock corporation of physicians, has entered into a *planning* contract with HEW to develop a mechanism for implementing PSRO in West Virginia.

Under this contract, the Institute was obligated to submit a *draft* of its proposed operational plan by October 24. The contract calls for completion of work on a final version of the plan by December 24. The draft reflects work by the Institute staff under direction and guidance of the Board of Trustees, with input from individual physicians on the Board and a three-member Board subcommittee on some specific organizational components —and that draft now is in the hands of the HEW staff.

The Organizational Components

Initial implementation of PSRO in West Virginia —to be done as the Institute members and leadership direct—will embrace inpatient care provided Medicare, Medicaid and Maternal and Child Health Program cases in short-stay hospitals. This is the care paid for from federal funds—and the overall objective of PSRO is to assure that such care falls within professionally established (by doctors) criteria with respect to the quality, necessity and appropriateness of the care. The initial PSRO plan framework must contain three basic components—mechanisms for admission certification; continued stay review, and generally continuous medical care evaluation studies.

Although all of West Virginia is included in a single PSRO area, the PSRO statute requires local-level professional review to the greatest possible degree, with revision or adoption of criteria and standards, including length-of-stay parameters, to meet varying local patterns of practice.

The draft of the West Virginia PSRO Plan accordingly proposes the division of the state into *nine districts* for professional review, while at the same time emphasizing that *such a district structure must, itself, be the subject of continuous review and probable reshaping* as medical service areas, for example, might undergo change because of new highway construction and other factors. The initial, and tentative, districts have been proposed on the basis of numbers of physicians; numbers of hospitals and hospital beds, and certain patient-flow patterns developed by a recent West Virginia Regional Medical Program study.

The tentative lineup looks like this: *District* 1, Brooke, Hancock, Ohio, Marshall, Wetzel and Tyler Counties; *District* 2, Wood, Pleasants, Ritchie, Wirt, Calhoun, Gilmer and Roane; *District* 3, Monongalia, Preston, Marion, Harrison, Taylor, Doddridge and Lewis; *District* 4, Upshur, Randolph, Pocahontas, Barbour and Tucker; *District* 5, Morgan, Berkeley, Jefferson, Hampshire, Mineral, Hardy, Grant and Pendleton; *District* 6, Jackson, Clay, Putnam, Kanawha, Boone and Braxton; *District* 7, Mason, Cabell, Wayne, Lincoln, Logan and Mingo; *District* 8, Webster, Nicholas, Fayette, Greenbrier, Raleigh and Summers; and *District* 9, Mercer, McDowell, Monroe and Wyoming.

The Operational Format—at the State Level

The state PSRO plan draft establishes the Medical Institute Board of Trustees, as the elected representatives of the Institute membership, as the overall policy-making board; with PSRO policy to be carried out through a State PSRO Coordinator and his staff reporting to the Board through the Institute Executive Director. The state structure also will include a number of committees (criteria and standards, utilization and evaluation, and—among the potentially more important— a multi-specialty advisory committee to handle reviews and/or any appeals necessary at the state level in view of small numbers or uneven distribution of specialists at the local and/or district level). The PSRO mechanism, to also include advisory groups as required by law, is envisioned as one of the two major Institute components—with the other Continuing Medical Education. The overall Institute structure will be further planned for maximum integration of PSRO and education activities, largely through a Medical Director serving in a staff capacity for both components.

District Level Operations

The plan draft provides, in the nine districts, for review committees of physicians (which will vary in size) representing the specialists and patterns of practice in the individual districts. Committee members will be appointed by the Board of Trustees after consultation with medical staffs at hospitals and/or institutions in the districts; local medical societies; local or other specialty groups, and with other physicians the Board deems advisable and appropriate. District Review Committee responsibilities will include service as appeal bodies; assistance in the developing, or adapting, of criteria and standards to meet patterns of practice in their areas; assessment of educational needs and resources; help toward assuring effective, and rotating, panels of physicians for professional review and related activity; and several other duties. The plan calls for PSRO Field Coordinators to work from the State PSRO Office, with and through the District Committees, in an overall link with professional review activities at the local hospital and medical staff level.

The Hospital-Medical Staff Level of Operations

It is recognized that (1) some hospitals and their medical staffs will seek from the PSRO full delegation of authority for all phases of basic activity covered by the state plan (admission certification, continued stay review and the conduct of medical care evaluation studies); (2) some may seek and obtain a partial delegation of authority; and (3) in other instances, all phases of review activity will be carried out by the PSRO. This is in line with, among other things, provisions in the current federal statute stipulating that where hospital review committees can meet professional review requirements and standards, they shall be permitted

to carry out those responsibilities with the PSRO serving in a monitoring, surveillance and data-collecting role.

This means that—under provisions of the draft plan—the PSRO will join with each hospital medical staff and other appropriate personnel for a detailed measuring of the effectiveness, and capability, of current in-house review activities—and then will enter into a memorandum of agreement with each such institution defining specific review processes, including the delegation to the hospital staff of any part of the review responsibility.

The plan thus also provides that such mechanisms as those for employment and reimbursement of such key local-level personnel as Program Coordinators and Physician Advisors will be matters for negotiation in completion of the various memoranda of agreement. The draft further provides that where there is NO delegation of any review responsibility at a hospital, the Program Coordinator and Physician Advisor will be chosen by the PSRO, with the latter to be appointed by the District Review Committee with the concurrence of the state PSRO structure and the Institute Board of Trustees.

Functions of the Program Coordinator at the hospital level will include initial admission certification and continued stay review determinations in line with PSRO policy, including criteria and length-of-stay parameters; the monitoring of patients and patients' records during hospital stay; and assistance to the Physician Advisor and/or other hospital and community personnel in discharge planning.

The Physician Advisor will review questions about admission certification, continued stay review, compliance with criteria and/or other appropriate matters brought to him by the Program Coordinator; confer with the attending physician regarding professional review questions; and grant or deny admission certification and/or extensions of stay as he feels documentation justifies.

Where whole or partial professional review authority is delegated by the PSRO to a hospital, and/or when the memorandum of agreement with the PSRO so stipulates, the Utilization Review Committee will serve as the initial level of review in disagreements between the Physician Advisor and attending physicians. Under other circumstances, the District Review Committees of physicians will serve as the first level of review.

Miscellaneous Items

Criteria and Standards—The plan calls for the Institute-PSRO structure to (1) adopt criteria in more than 270 diagnoses developed, field-tested and revised by the Medical Advances Institute (MAI) in Ohio; (2) submit these first to a general Institute Criteria and Standards Committee for *adaptation* to West Virginia patterns of practice; and (3) then subject the criteria to *further appropriate adaptation* in line with district and/or local practice patterns as the professional review system is *progressively developed* in the state.

Training and Indoctrination—to be developed with the PSRO structure—and, in fact, already in preparation—will be training and manual material for instruction and Program Coordinators, Physician Advisors and others involved in the review process.

Involvement of Non-Physician Health Care Providers—While specific HEW guidelines still are in preparation, the draft makes provisions for involving non-physician health care providers (podiatrists, doctors of dental surgery, nurses, therapists, etc.) in the professional review program as they might have working relationships with it.

Drs. Esposito and Wells Elected To Serve in Legislature

Drs. Albert C. Esposito of Huntington and Hawey A. Wells, Jr., of Princeton, were successful in their initial bids for election to the West Virginia House of Delegates in the November 5 general election.

Doctor Esposito's bid for a seat in the House of Delegates was his first attempt to be elected to public office. As the final results were tallied he emerged as one of only two new Republican members of the Legislature who will be sworn into office when that body is convened in Charleston next month.

Doctor Esposito will serve as one of six members of the Cabell County delegation which makes up the Eleventh District.

Doctor Esposito has practiced his specialty of ophthalmology in Huntington since 1946 and has been active in civic and public affairs for many years. In organized medicine, he is a Past President of the Cabell County Medical Society, the West Virginia State Medical Association and the Southern Medical Association. He has served as a member and chairman of several key committees of the State Medical Association and was just recently named President Elect of the American Academy of Ophthalmology. In recent years, Doctor Esposito has been among the leaders of a movement toward the establishment of a medical school at Marshall University.

Doctor Wells, who practices his specialty of pathology in Princeton, attended the two-year West Virginia University School of Medicine and received his M.D. degree in 1960 from the Medical College of Virginia. He interned and served a residency at the Medical College of Virginia and served as a Senior Assistant Surgeon in the field of pathology with the United States Public Health Service. Prior to establishing his practice in Princeton, he served as a pathologist at the Uniontown Hospital in Pennsylvania and also as Assistant Professor of Pathology at the West Virginia University School of Medicine.

Doctor Wells has practiced in Princeton since 1971 and currently is serving as President of the Mercer County Medical Society. In his only other bid for public office he was defeated for a seat in the United States House of Representatives several years ago.

His wife, Margaret, a graduate of the WVU School of Medicine, is a family physician and also practices in Princeton.

The wives of two physicians were unsuccessful in the November election. Mrs. J. A. B. Holt of Charleston was defeated in an attempt to seek reelection as a member of the House of Delegates while Mrs. William D. Crigger of South Charleston failed in her initial bid for a seat in the House.

Doctor Bobbitt Elected Member Of Foundation Board

Dr. John M. Bobbitt of Huntington has been elected a member of the Board of Trustees of the Huntington Clinical Foundation, Inc., succeeding his late father, Dr. Ray M. Bobbitt, one of the first medical members of the Board. Other physicians and dentists serving on the Board are Walter R. Wilkinson, M.D., Winfield C. John, M.D., and J. Bernard Poindexter, Jr., D.D.S., who is currently serving as President of the Foundation.

The Foundation was founded in 1948 to receive one-third of the residuary estate of the late Rufus Switzer, a former Mayor of Huntington, to expend its funds for the "treatment, study or research of human disease." The other two-thirds of the residuary of the estate goes to the Huntington Galleries, Inc.

The late Drs. Walter E. Vest and Robert J. Wilkinson, who like Doctor Bobbitt, were Past Presidents of the West Virginia State Medical Association, were among the original nominees to the Board. Doctor Bobbitt at one time served as President of the Foundation while Doctor Wilkinson was Treasurer.

Original incorporators were: H. K. Eutsler, Huntington lumber executive; Robert J. Wilkinson, Jr., at the time a clinic administrator and now a resident and educator of Roanoke, Virginia; the late Douglas C. Tomkies, Mayor of Huntington in 1948; the late Elliott Vawter; and the late Harry P. Henshaw, a Vice President of the Chesapeake and Ohio Railway Company.

When the Foundation was in its infancy its projects included the providing of office space—rent free—to the American Cancer Society and the American Heart Association. It purchased and donated to St. Mary's Hospital a special type camera for taking enlarged pictures of pathologic specimens.

The Foundation also has financed the medical-social service index, located in the Cabell-Huntington Health Department.

One of its more recent expenditures was for the education of a pastoral counselor at the Menninger Clinic at Topeka, Kansas, to enable him to better counsel with patients in the hospital environment.

Change of Address

Members of the West Virginia State Medical Association are requested to notify the headquarters offices promptly concerning any change in address. Notices should be mailed to Box 1031, Charleston, West Virginia 25324.

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled in the coming months.

1974

Dec. 1-6—Radiological Society of N. America, Chicago.
Dec. 6—Am. Coll. Chemosurgery, Chicago.
Dec. 7-10—Am. Soc. Hematology, Atlanta.
Dec. 7-12—Am. Acad. Dermatology, Chicago.
Dec. 9-12—Southern Surgical Assn., Boca Raton, Fla.
Dec. 10-11—Am. Medical Soc. on Alcoholism, San Francisco.
Dec. 11-15—Am. Psychoanalytic Assn., N. Y. City.
Dec. 16-17—New Drug Sem. (Natl. Cancer Institute), Washington, D. C.

1975

Jan. 9-11—Symp. on Late Consequences of Successful Cancer Therapy, Orlando, Fla.
Jan. 24-26—8th Annual Mid-Winter Clinical Conf., Charleston.
Jan. 29-Feb. 1—Southern Society for Pediatric Research, New Orleans.
Jan. 31-Feb. 2—Southern Radiological Conf., Point Clear, Ala.
Jan. 31-Feb. 2—AMA Congress on Medical Education, Chicago.
Feb. 10-13—Am. College Cardiology, Houston.
Feb. 13-15—Am. Coll. Emergency Physicians, Seattle.
Feb. 13-15—Southern Neurosurgical Soc., San Antonio.
Feb. 15-19—Amer. Acad. of Allergy, San Diego.
Feb. 17-20—Southeastern Surgical Congress, Atlanta.
Feb. 21-28—Am. Soc. of Clinical Pathologists and College of Am. Pathologists, Las Vegas.
Feb. 28-Mar. 5—Am. Soc. of Abdominal Surgeons, Orlando, Fla.
Mar. 1-4—Am. Assn. Pathologists & Bacteriologists, New Orleans.
Mar. 1-6—Am. Acad. of Orthopaedic Surgeons, San Francisco.
Mar. 7-9—AMA-AMPAC Public Affairs Workshop, Washington, D. C.
Mar. 13-19—Am. Coll. of Allergists, Bal Harbour, Fla.
Mar. 20-21—Natl. Conf. of Rural Health, Roanoke, Va.
Mar. 30—April 4—Am. Coll. of Radiology, Portland.
Apr. 6-10—Am. Assn. Neurological Surgeons, Miami Beach.
Apr. 9-12—Am. Gynecological Soc., Phoenix, Arizona.
Apr. 14-16—Am. Assn. for Thoracic Surgery, N. Y. City.
Apr. 28-May 3—Am. Acad. of Neurology, Bal Harbour, Fla.

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WVU Medical Center
–News–

• **Compiled from material furnished by Mrs. Mary Ellin Wylie, Director, Medical Center News and Information Services, Morgantown, W. Va.**

ONE professor and four assistant professors have been appointed to the faculty of the Department of Pathology, West Virginia University School of Medicine.

Dr. Winfield S. Morgan, named Professor of Pathology and Director of Surgical Pathology, comes to WVU from Case Western Reserve University School of Medicine, where he held the same academic rank. He also previously taught at the medical schools of Tufts and Harvard Universities.

A native of Takoma Park, Maryland, he received his undergraduate education at Albright College in Reading, Pennsylvania, and his M. D. degree from Temple University.

His special training includes a year in Oxford, England, as a British-American Exchange Fellow of the American Cancer Society and as a special research Fellow of the National Cancer Institute, studying with Dr. Tore Hultin of the University of Stockholm, Sweden.

Holding a joint appointment as Assistant Professor in Pathology and Biochemistry is Singanallur N. Jagannathan, a native of India.

He was educated at the University of Bombay, where he received a B. S. degree in chemistry and physics and M.S. and Ph.D. degrees in biochemistry. He comes to WVU from the University of Iowa, where he was an associate research scientist at the Arteriosclerosis Research Center. His primary interest has been in the field of lipids as related to atherosclerosis and heart disease.

Also a native of India is Renu Jalota, who was educated at Panjab University and interned at the Medical College Hospital in Amritsar.

Her residency in pathology was served at the Post-Graduate Institute of Medical Education and Research in Chandigarh and at the University of Utah Medical Center in Salt Lake City, where she also served as an Instructor in Pathology.

WVU graduate Jesse Jay Jenkins, III, comes to WVU from the University of Pittsburgh where he was Chief Resident in Pediatric Pathology at the University Health Center and Children's Hospital.

Receiving his M. D. degree from Johns Hopkins University, he served both his internship and residency at the University of Pittsburgh.

Shailbala Shah, a native of Zanzibar, Tanzania, joined the Department of Pathology as an Assistant Professor after completing her residency in anatomic and clinical pathology at WVU.

A graduate of the University of Bombay, Doctor Shah served her internship in that city before coming to the United States in 1970.

Chemotherapy and Breast Cancer

A West Virginia University tumor specialist believes chemotherapy presents the best chance for long term survival without recurrence for women whose pathology report following removal of a cancerous breast shows positive lymph node involvement.

"We have the greatest chance of killing all of the remaining cancer cells when the tumor load is lowest," said Dr. Raymond B. Weiss, Assistant Professor of Medicine in the WVU School of Medicine, and University Hospital oncologist.

Doctor Weiss' conclusion is based on his participation in a cooperative research study now being conducted in 30 hospitals throughout the United States, Canada and Great Britain under the sponsorship of the National Cancer Institute (NCI).

Although chemotherapy for metastatic breast cancer has been in general use for more than 10 years, the treatment of post-surgical patients with drugs to prevent recurrence is a recent concept.

"The early results are promising," said Doctor Weiss, "but the study has not been going on long enough for a complete evaluation." Three groups of patients are involved in the breast cancer studies at the Medical Center.

The first is what Doctor Weiss terms the high risk group—those most likely to have a recurrence of their cancer within five years following surgery. Into this category he places those women who have four or more positive lymph nodes.

"These women have an 85-90 per cent risk of cancer return in five years," Dr. Weiss said. "About half will have a recurrence within 18 months. We want to prevent this relapse instead of waiting."

The second study is of pre-menopausal women who have had a recurrence and who are candidates for treatment by hormonal deprivation (ovary removal).

"We believe the addition of drugs to the treatment of these patients will result in better control and longer survival," Doctor Weiss said.

Chemotherapy also is indicated for a third group —post-menopausal women with recurrence not helped by standard hormonal therapy.

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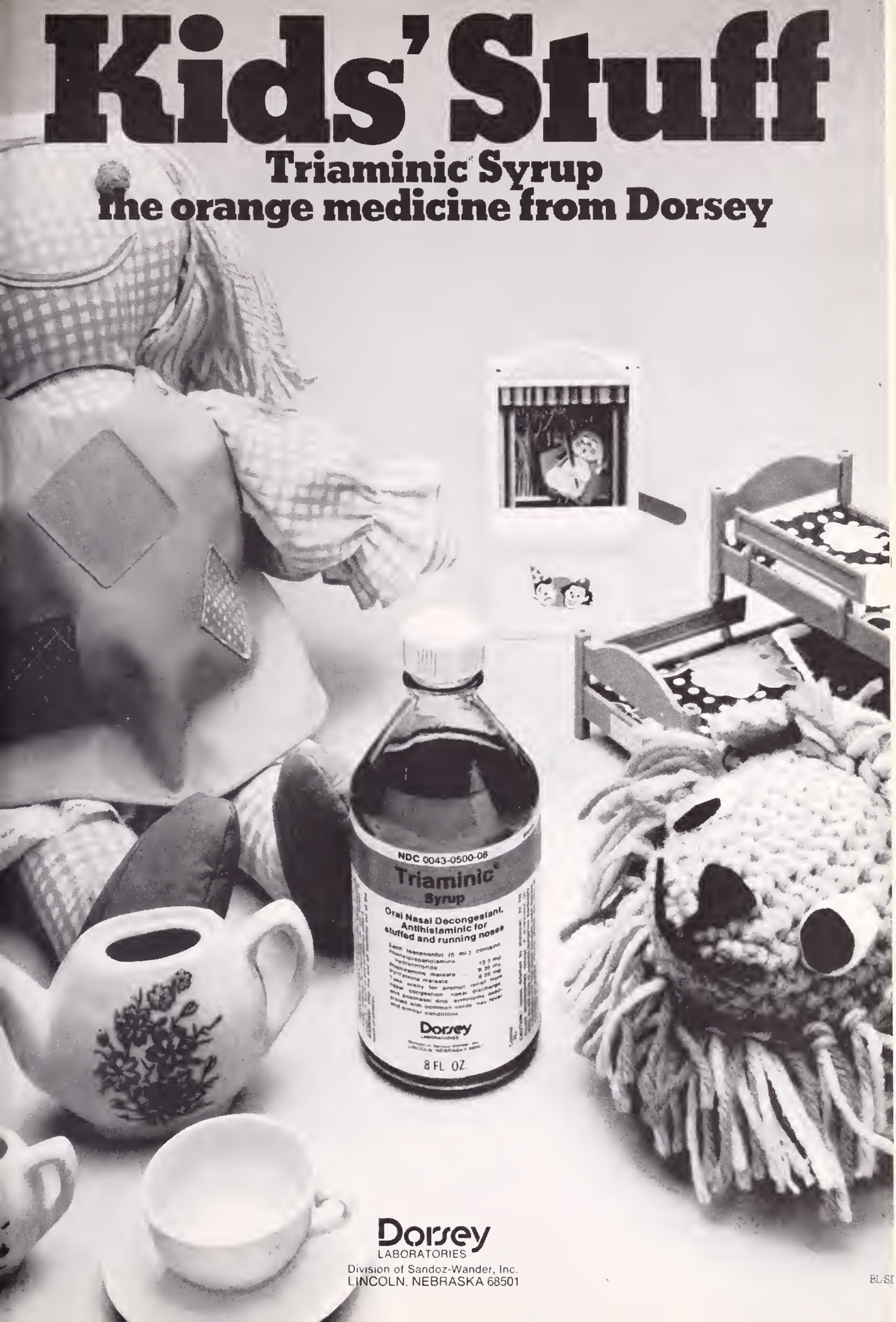

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The Month in Washington

• **From the Washington Office of the American Medical Association.**

THOUGH Senator Russell Long (D-La.) may make an attempt to win Senate approval of his social security-catastrophic national health insurance proposal when the Congress returns in late November, most Capitol Hill observers believe such legislation's chances of passage are less than that of Henry Mencken's snowball in hell.

The American Medical Association is now in the process of reviewing and updating its position on national health insurance, Malcolm C. Todd, M.D., has told Washington groups.

"Our objective is to make the AMA's national health insurance proposal more flexible, while at the same time maintaining certain basic precepts," Doctor Todd said.

"If necessary, we may compromise on the method of financing we adopt. But we are not willing to fund national health insurance through an increase in Social Security taxes; nor are we willing to see the program administered by the Social Security Administration.

"We want a financing mechanism for comprehensive health insurance that will do the most at the least cost. This could involve:

—Increase employer-employee contributions for private health insurance;

—The use of general tax revenues;

—Or, an individual tax credit to be applied toward full health care protection. This latter method was, of course, the method employed in Medicredit.

"The important point is that we cannot countenance greater fiscal and bureaucratic authority for the Social Security Administration or an increase in the Social Security tax.

"Any payroll tax, whether collected under Social Security or not, constitutes the most insidious form of taxation that can be invoked by government. It is a totally regressive tax that weighs heavily on low and middle-income workers and lightly on the affluent.

"Finally, the measure that emerges will provide comprehensive health care benefits as well as protection against the catastrophic costs of prolonged illness for every American," Doctor Todd said.

Action Expected on Health Legislation

A batch of major health bills are hanging afire for the "lame duck" session of Congress starting November 18. Comprehensive health planning bills have cleared the Senate but not the House. Though no public utility-type regulation is in prospect, other measures strengthening government planning authority abound.

Health manpower legislation with provisions for federal service in shortage areas is through the Senate. House action is expected shortly after Congress returns. There is a possibility that one or both may be stalled in conference as the Administration now wishes simple extension of present programs.

A health revenue sharing bill will be taken up again by a House-Senate conference. This measure extends state health block grants, community mental health centers, family planning, migrant health and neighborhood health center programs. It should secure Congressional enactment this year.

The Health Education and Welfare appropriations bill still has to be completed.

No chance is seen for passage of the Omnibus Drug amendments bill that would provide Medicare outpatient drug benefits, a Federal Formulary, and the Administration's low-cost drug plan for Medicare-Medicaid patients.

HMO Regulations Issued

The Health Education and Welfare Department has issued final regulations on benefits and structure of Health Maintenance Organizations, giving the green light to federal grants launching the program.

The regulations set forth the rules and restrictions and benefits that must be followed in order for organizations to qualify as HMO's and receive federal aid. The $325 million HMO program was approved by Congress in 1973.

Grants can now be made among the 125 groups that have applied for funds to conduct feasibility studies, planning and development.

The HMO Act authorizes federal support for five years "to demonstrate more broadly the concept of organizations delivering comprehensive health care services on a prepaid basis." Last year Congress appropriated $61 million. The Administration sought $60 million this year, but the Senate approved only $18 million because of a delay due to the development of the complicated regulations.

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Obituaries

DON V. HATTON, M. D.

Dr. Don V. Hatton of Williamson died on October 19 at his home. He was 61. A native of Washington, D. C., Doctor Hatton was an internist and a former staff member of Williamson Memorial Hospital. He attended public schools in Huntington and was graduated from Marshall University. He received his M. D. degree in 1936 from George Washington University.

Doctor Hatton served an internship and residency at Norton Memorial Infirmary in Louisville, Kentucky during 1936-38 and received an M. P. H. degree in 1942 from Johns Hopkins University. He was a Diplomate of the American Board of Internal Medicine and a Fellow of the American College of Physicians. He was a member of the Mingo County Medical Society, the West Virginia State Medical Association and the American Medical Association.

Doctor Hatton practiced medicine for a short time with the Departments of Public Health in West Virginia and Kentucky, and briefly practiced internal medicine with Veterans Administration hospitals in Huntington and Louisville. He had practiced internal medicine since 1943 in the Williamson area.

Survivors include the widow; two daughters, Mrs. Judith Sinkhorn of Louisville, Kentucky and Mrs. Donna Peters of Huntington; two sons, Don C. Hatton of Houston, Texas and Russell Hatton of Buffalo, New York; a brother, Roy Hatton of Huntington; and two sisters, Mrs. Katherine McCoy and Mrs. Josephine Bartram of Huntington.

JAMES H. WOLVERTON, M. D.

Dr. James H. Wolverton, long-time family physician in Piedmont (Mineral County), died on November 6 at his home. He was 93. Doctor Wolverton began his practice 66 years ago in Arizona and Texas and was located in Piedmont for 57 years. A native of Piedmont, he returned to his home town in 1917 and practiced until his retirement last February.

Doctor Wolverton was a graduate of Hampden-Sydney College and received his M. D. degree in 1909 from the University of Louisville School of Medicine. A Diplomate of the American Academy of Family Physicians, he was a member and Past President of the Potomac Valley Medical Society, and a member of the West Virginia State Medical Association and the American Medical Association.

Doctor Wolverton served as Mineral County Health Officer from 1929 until 1943 and also was industrial surgeon for the B&O Railroad and Western Maryland Railway. He served on the Piedmont City Council from 1926 until 1940.

Survivors include the widow; two sons, Dr. James H. Wolverton, Jr., of St. Petersburg, Florida and Dr. William R. Wolverton of Cumberland, Maryland; and three daughters, Mrs. Ruth Cupett of Petersburg, Mrs. Kathryn Carvey of Keyser and Mrs. Harriet Hackney of Charleston.

GEORGE E. SNIDER, M. D.

Dr. George E. Snider of Bluefield, an internist, died on October 22 in a Roanoke (Va.) hospital following a long illness. He was 63. A native of Pulaski, Virginia, Doctor Snider was a member of the staff of St. Lukes Hospital in Bluefield.

He earned B. S. and M. S. degrees from Virginia Polytechnic Institute, and received his M. D. degree in 1940 from the Medical College of Virginia. He interned at that institution.

Doctor Snider served as a major in the U. S. Army Medical Corps during 1941-46, and was Assistant Chief of Medical Service at Fort Howard in Maryland during 1946-49. He was a member of the Mercer County Medical Society, the West Virginia State Medical Association and the American Medical Association.

Survivors include the widow; two sons, Dr. George E. Snider, Jr., of Roanoke and John Tracy Snider of Bluefield; and two sisters, Mrs. George Wood of Abingdon, Virginia and Miss Elizabeth Ann Snider of Pulaski.

JOSEPH E. MARTIN, JR., M. D.

Dr. Joseph E. Martin, Jr., of Elkins, a pioneer in the research and discovery of pneumoconiosis, died on November 2 after an extended illness. He was 67.

Doctor Martin, who conducted black lung research for more than 20 years, was one of the four founders of the Memorial General Hospital in Elkins, formerly known as the Golden Clinic. A native of Hundred, in Wetzel County, Doctor Martin was graduated from West Virginia Wesleyan College and received his M. D. degree in 1933 from Case Western Reserve University School of Medicine. He interned at City Hospital in Cleveland, 1933-34.

A Major with the U. S. Army Medical Corps during World War II, Doctor Martin was an internist and was certified by the American Board of Internal Medicine in 1949. He was a member of the Tygart's Valley Medical Society, the West Virginia State Medical Association and the American Medical Association.

Survivors include the widow; two daughters, Mary Schneider of the Canal Zone and Jane Jesson of Missoula, Montana; two sons, Joseph E. Martin, III, and John S. Martin; a sister, Mrs. Mary McCoy of Sistersville; a brother, Dr. James F. Martin of Winston-Salem, North Carolina; and four grandchildren.

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County Societies

MERCER

Congressman Ken Hechler was the guest speaker at the meeting of the Mercer County Medical Society on October 21 in Princeton at the Dinner Bell restaurant. There were 54 members and guests in attendance.

Congressman Hechler, who was introduced by Dr. Hawey A. Wells, Jr., President, discussed legislation which had been passed enabling Marshall University to establish a medical school. Emphasizing that West Virginia needs more primary care and general practice physicians, he stated that the first class of 24 students would definitely be admitted in 1977 but may possibly be admitted in September 1976. The Dean of the Marshall Medical School, Dr. Robert C. Parlett, was to visit Mercer County the following week to confer with doctors. —John J. Mahood, M. D., Secretary.

McDOWELL

The McDowell County Medical Society met on October 23 at Doctor's Memorial Hospital in Welch. Considerable material from the previous summer was presented and discussed. The Society approved the purchase of an ad for $35 for "The Pylon," the yearbook of the West Virginia University School of Medicine.

A letter from the State Medical Association was read informing members of an increase in State dues from $100 to $150, and another letter from Dr. C. A. Hoffman of Huntington, Chairman of the State Medical Association's Insurance Committee, informing members of an increase in malpractice insurance premiums.

Correspondence was presented by Dr. John S. Cook regarding the use of Methadone in rural areas. He expressed the hope that arrangements could be worked out for using Methadone in these areas.—Arthur A. Carr, M. D., Secretary.

MONONGALIA

The Monongalia Medical Society met on October 1 in Morgantown at the Old Mill Club. The speaker for the evening was Dr. William A. Neal, Assistant Professor in the Department of Pediatrics at the West Virginia University Medical Center. Doctor Neal spoke on "Neonatal Intensive Care."

Dr. Isaiah A. Wiles gave the report of the Public Health Committee, observing that October was "Immunization Month." Doctor Richard S. Kerr discussed the time of giving Rubella and questioned giving it in early infancy. Following this, there was a lengthy discussion of the problem of Rubella immunization.

Dr. Carl E. Johnson was elected an honorary member of the Society.—H. Summers Harrison, M. D., Secretary.

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HARRISON

The regular monthly meeting of the Woman's Auxiliary to the Harrison County Medical Society was held at the Sheraton Inn in Clarksburg on November 7.

An interesting program on the "Battered Child Syndrome" was presented and the two guest speakers were Mrs. Robert O. Pletcher and Mr. John F. McCuskey, both of Clarksburg.

Mrs. Pletcher, a member of the Auxiliary, has taken postgraduate work in community psychology and received a Master of Science degree in social work from West Virginia University.

Mr. McCuskey, a member of the West Virginia House of Delegates, spoke on the legal and legislative aspects of child abuse and a short film was presented.

Guests at the meeting included Mrs. William T. Lawson, President of the State Auxiliary, and Mrs. Kenneth D. Bailey, Corresponding Secretary—Mrs. Richard F. Fiester, Publicity Chairman.

TV Violence and Human Aggression

"If you believe there's a link between cigarette smoking and cancer, then you probably ought to believe there's a link between watching TV violence and human aggression."

That's the "cautious conclusion" of a communications researcher writing about the effect of televised violence on children in a recent issue of *News & Comment*, the monthly membership publication of the American Academy of Pediatrics.

Noting that "violence in our society is becoming a major health problem," Randall P. Harrison, Ph. D., said that "the average American child between the ages of five and fifteen sees some 13,400 human beings destroyed on his television screen. In growing up, the typical child spends as much time with television as he does in our educational system. He spends more of his waking hours watching TV than in any other single activity."

Does the viewing of this much violence cause aggressive behavior in children? Doctor Harrison said the research indicates it does.

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Book Reviews

ESSAYS ON LONGEVITY — By Samuel Kahn, M.D. Philosophical Library, Inc., 15 E. 40th St., New York, N.Y. 1st Edition 1974. Pg. 196. Price: $10.00.

The author of this small volume—196 pages and also 22 others—is a psychoanalyst and prominent educator with many years of hospital and teaching experience.

Longevity, geriatrics and gerontology are important subjects to all of us as we are influenced by such interests, directly or indirectly now or we will be in the future, for with modern medical and surgical care our aged population will increase for certain.

The sections or chapters are well-arranged for periodic reading, which is pleasureable and informative as well.

The summation of aging is the best I have read. A splendid glossary defines all medical terms.

Our own Dr. E. J. Van Liere is quoted in the chapter on "Preventive Treatment" on "Exercise and Marked Weight Reduction," and he states for all of us that "The most telling exercise for a trim figure is to push the chair away from the dining table."

The book is highly recommended.—C. Frederick Fisher, M.D.

CURRENT SURGICAL DIAGNOSIS AND TREATMENT — By J. Englebert Dunphy, M.D.; and Lawrence W. Way, M.D. Lange Medical Publications, Los Altos, California.

This volume of more than 1,000 pages is a very concise and detailed history of surgical diagnosis and treatment for the busy, active surgical practitioner. Essential information is listed in such a way as to be immediately available with strong emphasis on points to consider in differential diagnosis of the problem as presented in any given patient.

In its various sections devoted to specific categories, the specialist, as well as the general surgeon, will find quick reference to early diagnosis of his problems, both benign and malignant conditions or disease. All disease conditions are covered adequately and the specialist will find information as useful to him as to general surgeons.

In addition, extensive and detailed listing of laboratory procedures are given and which tests can confirm or rule out any particular disease.

Each section gives a short description of physiology and indicates which abnormal report points to which abnormal condition or disease.

Throughout the book great emphasis is placed on history, symptoms, signs and thorough physical examination. The meaning and interpretations of abnormal findings suggesting the most

(Continued On Page xxi)

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likely disease process is also brought out. A complete study of methods of treatment in any given disease is presented for each disease condition.

The book is well-illustrated by anatomical drawings of embryology, normal anatomy and disease states with extensive tables which may be consulted.

I believe this is a very valuable book and would be a timely and welcome addition to any surgeon's library. I sincerely recommend it.—Andrew J. Weaver, M.D.

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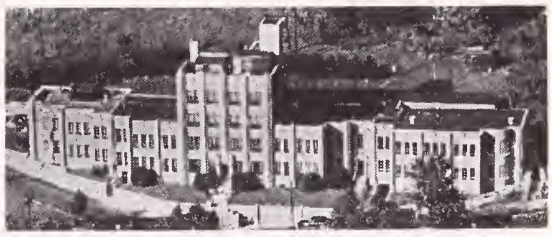

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Note: The increasing frequency of resistant organisms limits the usefulness of antibacterials, especially in chronic and recurrent urinary tract infections.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia in elderly patients on diuretics, primarily thiazides. Sore throat, fever, pallor or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted. Data are insufficient to recommend use in infants and children under 12.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, allergy or bronchial asthma; and in those with glucose-6-phosphate dehydrogenase deficiency, where hemolysis may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for children under 12.

Usual adult dosage: Two tablets b.i.d. for 10 to 14 days. For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	2 tablets every 24 hours
Below 15	Use not recommended

Supplied: Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 1000; Prescription Paks of 40, available singly and in trays of 10.

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